

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03788

## CERTIFICATE OF DEATH

03784

1. PLACE OF DEATH e. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b> d. STREET ADDRESS <b>110 CLEARVIEW RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES DANIEL BAER SR.</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>24</b> Year <b>1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/16/1901</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR Months <b>60</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UTILITY CO.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN L. BAER</b>	
14. MOTHER'S MAIDEN NAME <b>MARY E. CORDERMAN</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>217-10-9583</b>		17. INFORMANT <b>MRS. CATHERINE E. BAER</b> Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Arterio sclerotic cardiovascular disease</b> DUE TO (c) <b>Arterio sclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>3 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <b>15 Mar 1962</b> to <b>24 Mar 1962</b> , that (I) (we) last saw the deceased alive on <b>23 Mar 1962</b> , and that death occurred <b>130 A</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>F.F. Lusby</b>		22b. DATE SIGNED <b>3/24/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.F. Lusby</b>		22d. ADDRESS <b>2300 Potomac St Hagerstown Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/26/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BROADFORDING CH</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON CO. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.J. Normant</b>		25a. RECEIVED BY REGISTRAR <b>CEM.</b> DATE <b>MAR 27 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

03780

CERTIFICATE OF DEATH

03780



# 1 FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
SM 9/60

## 03789 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03785

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN lb <b>10 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>15 S. POTOMAC ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JACOB HENRY BAKER</b>				4. DATE OF DEATH Month Day Year <b>MARCH 1 19 62</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/22/1886</b>		9. AGE (In years last birthday) <b>75 Yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FRUIT FARM</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH BAKER</b>				14. MOTHER'S MAIDEN NAME <b>MARY KING</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W.W.#1</b>		17. INFORMANT <b>MR. THEODORE BROWN</b>		Address #2 <b>WILLIAMSPORT MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X cerebral vascular hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>gen. arteriosclerosis &amp; hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>years</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Howard N. Weeks, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3/3/62</b>	
EXAMINER'S NAME (Type) <b>Howard N. Weeks, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>3/5/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L CEM.</b>	
23. BURIAL DIRECTOR <b>W. J. Norment, Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 6 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

00183

00183



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03786

FOR STATE  
HEALTH DEPT.

03790

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> e. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u> d. STREET ADDRESS <u>12 EAST BALTIMORE ST.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN b. PLACE OF EMPLOYMENT <u>ROLL ON TIRE CO. E. WILSON BLVD</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROLL ON TIRE CO. E. WILSON BLVD</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>CONARD CLAYTON BEACHLEY</u>				<b>4. DATE OF DEATH</b> <u>MARCH 16 1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEBRUARY 20 1939</u>	
9. AGE (In years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>26</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TIRE REPAIRMAN - ROLL ON TIRE CO.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BOONSBORO WASH. CO. MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>AUSTIN BEACHLEY</u>			
14. MOTHER'S MAIDEN NAME <u>MARIE WAGAMAN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>REG. ARMY</u>			
16. SOCIAL SECURITY NO. <u>215-34-3931</u>				17. INFORMANT <u>MRS. DAISY BEACHLEY</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Of Skull</u> DUE TO <u>915.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>While inflating tube tire blew up.</u> DUE TO <u>715.3</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>While inflating tube tire blew up.</u>			
20c. TIME OF INJURY Month, Day, Year <u>6:25 p.m. 3-16-62 19</u>				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Place of employment. Hagerstown, Washington, Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. W. Ditto, Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>MARCH 19 1962</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>				22d. LOCATION (City, town, or country) (State) <u>CLEARSPRING WASH. CO. MD</u>			
23. FUNERAL DIRECTOR <u>John H. Best</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 22 '62</u>			
ADDRESS <u>BOONSBORO MD</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03787

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro	
c. LENGTH OF STAY IN 1b 1 mo.		d. STREET ADDRESS 72 Mt. Vernon Terrace	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Pierce E. Beaver		4. DATE OF DEATH March 3 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1907
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Sales		10b. KIND OF BUSINESS OR INDUSTRY Landis Tool Co.	
11. BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Gross Beaver		14. MOTHER'S MAIDEN NAME Drucie M. King	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 321 09 7401	
17. INFORMANT Mrs. Pierce E. Beaver		Address Waynesboro, Penna.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation (probably) 4-20-0 DUE TO (b) Atherosclerotic (Coronary) Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 7 few minutes (found dead) 3 year -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Ventricular tachycardia intermittently past month		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour e.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-10, 1961, to 3-3, 1962, that (I) (we) last saw the deceased alive on 3-3, 1962, and that death occurred at 4:50 A.M. from the causes and on the date stated above.		22a. SIGNATURE John H. Hornbaker M.D.	
22b. DATE SIGNED 3-4-62		22c. PHYSICIAN'S NAME (Type) JOHN H. HORNBAKER	
22d. ADDRESS 154 W. WASHINGTON ST. HAGERSTOWN - MD.		22e. REC'D BY REGISTRAR 22f. REGISTRAR'S SIGNATURE Arthur S. Thomas	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/62	
23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City, town or county) (State) Waynesboro, Franklin, Penna.	
24 FUNERAL DIRECTOR'S SIGNATURE Walter Z. Gure		25 ADDRESS Waynesboro, Penna.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03792

03788

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md.</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown Maryland</u> d. STREET ADDRESS <u>222 N. Jonathan Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles Summer Bell Sr.</u>		<b>4. DATE OF DEATH</b> Mar 27 1962	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb 21 1914</u>
<b>9. AGE</b> (In years last birthday) <u>48</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Porter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Hotel</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Hagerstown, Maryland</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Charles Bell</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Broom</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)	
<b>16. SOCIAL SECURITY NO.</b> <u>214-09-8963</u>		<b>17. INFORMANT</b> <u>Mrs Margaret Bell Hagerstown Md.</u> Address <u>  </u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic valvular heart disease with congestive failure</u> 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u>	
<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan. 18 1957</u> <b>to</b> <u>March 27 1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>March 26 1962</u> , <b>and that death occurred at</b> <u>1:45A</u> <b>M</b> , <b>from the causes and on the date stated above.</b>	
<b>22a. SIGNATURE</b> <u>B. B. Kneisley</u> M.D.		<b>22b. DATE SIGNED</b> <u>3/27/62</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>B. B. Kneisley, M.D.</u>		<b>22d. ADDRESS</b> <u>148 West Washington Street Hagerstown, Maryland</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4-1-1962</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Hagerstown, Maryland</u> (State) <u>  </u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John R Watson Jr Hagerstown Md</u>		<b>25a. REC'D BY REGISTRAR</b> <u>APR 3 '62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kline</u>		<b>25c. DATE</b> <u>APR 3 '62</u>	

3322



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03793						03789					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			WASHINGTON			a. STATE			b. COUNTY		
			MARYLAND						WASHINGTON		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
RURAL HAGERSTOWN			3 YRS.			03 HAGERSTOWN					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
AVALON MANOR						1 207 S. POTOMAC ST.					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
First Middle Last						Month Day Year					
MISS GEORGE LAREINE BESTER						MARCH 5 19 62					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days	
FEMALE		WHITE				2/8/1882		80 yrs.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED FLORIST				OWN FLORIST SHOP				MARYLAND		U.S.A.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
WILLIAM J. BESTER						MARY M. SUMMERS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO				NONE		MISS MARY E. BESTER		HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized &amp; cerebral arteriosclerosis</i>											
(c) <i>Hypertensive vascular disease</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH <i>About 24 hours</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-11, 1962</i> , to <i>3-3, 1962</i> , that (I) (we) last saw the deceased alive on <i>3-3, 1962</i> , and that death occurred at <i>11:50 A.M.</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>John H. Hornbaker</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>3-5-62</i>			
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.						22d. ADDRESS 154 W. Washington St., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
BURIAL			3/6/62			ROSE HILL CEM.			HAGERSTOWN MD.		
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Hornment</i>						ADDRESS <i>Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 12 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

03759

CONTINUATION OF DEATH

03759

M

1

154 W. Washington St.  
Bakersville, Va.

John H. Hornsby, M.D.

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03794

CERTIFICATE OF DEATH

03790

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>		X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>68 S. Main St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edgar</b> Middle <b>Brown</b> Last <b>Brenner</b>		4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1962</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 29, 1889</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>canning factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Smithsburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Walter D. Brenner</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Donaldson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219005-2869</b>	
17. INFORMANT <b>Miss Caroline Brenner, Smithsburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b> <b>1 Wk.</b> <b>15 Yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-3</b> <b>1954</b> to <b>3-22-62</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3-22-1962</b> , and that death occurred at <b>6:50 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Charles F. Hess</i>		22b. DATE SIGNED <b>3-23-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles F. Hess, M. D.</b>		22d. ADDRESS <b>Smithsburg, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>Mar. 25, 62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 27 '62</b>	
25b. REGISTRAR'S SIGNATURE <i>Carroll L. Thorne</i>			

14

03795

## CERTIFICATE OF DEATH

Reg. Dist. No. 03791

1. PLACE OF DEATH a. COUNTY <u>Washington, Ft Ritchie, Cascade</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Louisiana</u> b. COUNTY <u>Baton Rouge</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft Ritchie, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baton Rouge, Louisiana</u> 56x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>US Army Dispensary, Ft Ritchie, Md.,</u>				d. STREET ADDRESS <u>Route #5 Box#32</u>			
3. NAME OF DECEASED (Type or print) <u>HERMAN</u> First Middle Last <u>BROOKS JR</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>19 62</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Neg</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Jun 43</u>	9. AGE (In years lost birthday) <u>18</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fix Sta Rec Repmn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Army</u>		11. BIRTHPLACE (State or foreign country) <u>Oscar, Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>HERMAN BROOKS SR</u>				14. MOTHER'S MAIDEN NAME <u>MARY G. FEDINAND (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>139-625607</u>		17. INFORMANT <u>From Army Records By WILLIAM T GUZICK, CAPT., MSC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest following Grand Mal seizure.</u> 353 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>10-15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>16 March</u> , 19 <u>62</u> , to _____, 19____, that I last saw the deceased alive on <u>16 March</u> , 19 <u>62</u> , and that death occurred at <u>9:05</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Fort Ritchie, Cascade, Maryland</u> <u>3/16/62</u>							
ACTUAL SIGNATURE <u>Patrick J Ferraro Capt MC</u>				PHYSICIAN'S NAME (Type) <u>PATRICK J FERRARO, CAPT., MC</u> <u>US ARMY DISPENSARY, FORT RITCHIE, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glenn, La.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Marlin Roe</u>				ADDRESS <u>Waynesboro, Penna.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. ...</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director. The funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03792

03796

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY ---		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>DOA Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>425 George Street</b>		3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Day Brooks</b>		4. DATE OF DEATH Month Day Year <b>March 27 19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 May 1892</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Aircraft</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Luther Bush Brooks</b>				14. MOTHER'S MAIDEN NAME <b>Annie Catherine Kees</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW #1</b>		17. INFORMANT <b>Mrs. George Beard</b>		Address <b>Martinsburg, W.Va. 627 Faulkner Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Second, third and fourth degree burns involving</b> DUE TO <b>more than 60% of the body</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) 916.0									INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paralytic, it was necessary to use cane and crutch to ambulate</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Possibly smoking in bed</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>1:30AM p.m. 3-27-19 62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Hagerstown, Washington, Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>E. W. Ditto, Jr., M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. W. Ditto, Jr., M. D.</b>		Address (Street, city, town, or county) <b>3-27-62</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/29/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Martinsburg, Berkeley, W.Va.</b>			
23. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 30 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

MEDICAL CERTIFICATION

FOR STAR  
NEW YORK

0378

Washington

Washington

501 Washington County Hospital

55 George Street

Robert

Day

Brooks

March

white

22 May 1892

retired grand

Philadelphia Airport West Virginia

Walter Bush Brooks

Anna Catherine Rose

Yes We Al

22-12-1881 Mrs. George Reed 617 Lincoln Ave. Washington, D.C.

in

was in the body

3/29/62

Bowdoin Cemetery

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03797

CERTIFICATE OF DEATH

03793

Item 9 Film G309 3/29/62 iwk

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hosp.		d. STREET ADDRESS Ferry Farms	
3. NAME OF DECEASED (Type or print) Theodore Clifton BUCK		4. DATE OF DEATH Month 3 Day 24 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1869
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		9b. AGE (In years last birthday) 92 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hezekiah Best Buck		14. MOTHER'S MAIDEN NAME Emily Catherine Hoover	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. H. Marion Lazenby		Address Same	
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic brain syndrome (c) Cerebral arteriosclerosis DUE TO cause last, (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 days 4 years 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 5, 1961 to March 24, 1962 that (I) (we) last saw the deceased alive on March 24, 1962, and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun		22b. DATE SIGNED March 24, 1962	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-27-62	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc.		25a. REC'D BY REGISTRAR DATE MAR 27 '62	
ADDRESS 1900 Eutaw Place		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

08793

08793

M

Theodore Clifton Buck

James L. Buck  
Charles L. Buck  
Theodore Clifton Buck  
John L. Buck

YOUNG & CO.

John O. Nicholas & Son, Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03798											
03794											
Item 1 Film G309 3/21/62											
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>MORGAN</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BERKELEY SPRINGS</u> 85X-3			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON Co. Hospital</u>				d. STREET ADDRESS <u>1221 NOKKIS ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RONALD NEVIN CAPPER, JR.</u>				4. DATE OF DEATH <u>MARCH 2</u> 19 <u>62</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 3, 1962</u>		9. AGE (In years last birthday) yrs. <u>17</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown-Wash. Co. 17b</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RONALD N. CAPPER</u>				14. MOTHER'S MAIDEN NAME <u>VERONICA LEE KONGEL</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>RONALD CAPPER - Berkeley Springs</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity &amp; Secondary Atelias</u> 77115 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Petritial hemorrhage of viscera</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> , 19 <u>62</u> , to <u>3/2</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/2</u> , 19 <u>62</u> , and that death occurred at <u>7:20</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard A. Young M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Richard A. Young M.D.</u>				22d. ADDRESS <u>101 King St. Hagerstown, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>3-4-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND</u>		23d. LOCATION (City, town or county) (State) <u>Morgan Co. W. Va.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hunter</u>				ADDRESS <u>BERKELEY SPRINGS</u>				25a. REC'D BY REGISTRAR <u>DATE MAR 14 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Richard S. Hunter</u>	

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Removal of ...  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03799

03795

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN b <b>18 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASH. CO. HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b> d. STREET ADDRESS <b>NORTH MAIN ST</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANTOINETTE SHAFER CHANEY</b>		4. DATE OF DEATH <b>MARCH 7, 1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 29, 1868</b>
9. AGE (In years last birthday) <b>93 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BOONSBORO WASH. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD EASTBOURNE CHANEY</b>		14. MOTHER'S MAIDEN NAME <b>FANNIE WATSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>CHARLES SUMMERS BOONSBORO MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart Disease</b> <b>420</b> DUE TO (b) <b>due to Arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>Virus Infection</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>2969</b>		20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Boonsboro</b>		20g. (County) <b>Washington</b>	
20h. (State) <b>MD.</b>		20i. (City or town) <b>Boonsboro</b>	
20j. (County) <b>Washington</b>		20k. (State) <b>MD.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>March 7, 1962</b> to <b>March 7, 1962</b> and that death occurred <b>4:30 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>J. H. Sackley</b>	
22b. DATE SIGNED <b>March 7, 1962</b>		22c. PHYSICIAN'S NAME (Type) <b>J. H. Sackley</b>	
22d. ADDRESS <b>Boonsboro</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MARCH 10 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. MARKS EPISCOPAL CEMETERY</b>		23d. LOCATION (City, town or county) <b>LAPPANS WASH. CO. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Baer</b>		25a. REC'D BY REGISTRAR <b>March 13 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. ADDRESS <b>Boonsboro MD</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03800						03796					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)					
e. COUNTY <i>Washington</i>						e. STATE <i>West Virginia</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Williamsport</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Martinsburg</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Williamsport Sanitarium</i>						d. STREET ADDRESS <i>215 W. Race St.</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last <i>ANNA Lyon Chatkin</i>						Month Day Year <i>March 23 1962</i>					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
<i>Female</i>		<i>White</i>				<i>Dec 25 1888</i>		<i>73</i> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Owner-Operator Store Store</i>				<i>Europe</i>				<i>U.S.A</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
<i>Jacob Lyon</i>				<i>Minnie Socks</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
<i>no</i>				<i>Unable to locate</i>				<i>Chambersburg Penna</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-vascular Collapse</i>										<i>2 hrs</i>	
571.1 DUE TO											
Conditions, if any, which gave rise to immediate cause (b) <i>Acute gastroenteritis</i>										<i>8 hrs</i>	
(e), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<i>Severe Arteriosclerosis</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour e.m. p.m.		<i>19</i>		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from <i>1-22</i> , 19 <i>61</i> to <i>3-23</i> , 19 <i>62</i> that (II) (we) last saw the deceased alive on <i>2-23</i> , 19 <i>62</i> and that death occurred at <i>3:43</i> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>ME Byrkit</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>3-23-62</i>		
22c. PHYSICIAN'S NAME (Type) <i>ME BYRKIT</i>						22d. ADDRESS <i>Williamsport Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
<i>Burial</i>		<i>3/25/62</i>		<i>B'Nai Abraham Cemetery</i>				<i>Half way near Hagerstown Md</i>			
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<i>Andrew K. Coffman</i>						<i>Hagerstown Md.</i>		<i>MAR 27 '62</i>		<i>Arthur S. Kline</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03801 CERTIFICATE OF DEATH 03797

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 30 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 34 N. Locust St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
f. STREET ADDRESS 1 34 N. Locust St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Reynolds Parker Divens		4. DATE OF DEATH Month Day Year March 30, 19 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1907
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) finisher		10b. KIND OF BUSINESS OR INDUSTRY shoe mfg.	
11. BIRTHPLACE (County & State, or foreign country) Knobsville, Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lennuel Divens		14. MOTHER'S MAIDEN NAME Maude Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-5773	
17. INFORMANT Address Melvin C. Rager, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Acute Alcoholism		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/27/62 to 3/30/62, that (I) (we) last saw the deceased alive on 3/30/62, and that death occurred at 3:00 P.M. from the causes and on the date stated above.		22a. SIGNATURE M.D. 22b. DATE SIGNED 3/31/62	
22c. PHYSICIAN'S NAME (Type) H. Brachley		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4-2-62	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE APR 3 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. House			

(M)

03703

03703

Washington

Director

Director

Mr. Robert H. ...

Mr. Robert H. ...

Hayden

Hayden

White

Oct. 22, 1907

Lincoln

Shaw

Shaw

General Division

General Division

Director

Director

*Handwritten signature*

*Handwritten signature*

W-2-02

W-2-02

Scott J. Minnich, Son, Harpersburg, N.Y.

Harper's



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03802					03798									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY <b>Washington</b>					a. STATE <b>Maryland</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>					b. COUNTY <b>Washington</b>									
c. LENGTH OF STAY IN 1b <b>55 years</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>					d. STREET ADDRESS <b>1742 Jefferson Blvd.</b>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last <b>Clarence Edward Easterday</b>					Month Day Year <b>March 8 1962</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 20, 1877</b>		9. AGE (In years last birthday) <b>84 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Near Wolfesville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME <b>Lawrence Easterday</b>					14. MOTHER'S MAIDEN NAME <b>Ellen Herr</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>214-10-3455</b>					16. SOCIAL SECURITY NO. <b>214-10-3455</b>					17. INFORMANT Address <b>Mrs. Olive M. Easterday Hagerstown.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Ventricular fibrillation</b> DUE TO <b>Arteriosclerotic heart disease</b> (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Gangrene, left leg with above knee amputation due to generalized arteriosclerosis</b> (c)										<b>Minutes</b> <b>Indefinite</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of rectum, treated 1952</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19 -- --</b>										20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> <b>at work at work</b>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State) <b>7-5-52 19 to death 19 to death</b>				
21. I certify that (I) (this hospital) attended the deceased from <b>3-7-62</b> to <b>8:23 AM</b> death, 19 <b>19</b> , that (I) (we) last saw the deceased alive on <b>3-7-62</b> , and that death occurred at <b>8:23 AM</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Robert F. Keadle</b> M.D.										22b. DATE SIGNED <b>3-8-62</b>				
22c. PHYSICIAN'S NAME (Type) <b>Robert F. Keadle, M. D.</b>										22d. ADDRESS <b>Hagerstown, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>										23b. DATE THEREOF <b>3-10-62</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>										23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son Hagerstown, Md.</b>										25a. REC'D BY REGISTRAR <b>MAR 12 '62</b>				
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kress</b>														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03803

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1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u>		c. LENGTH OF STAY IN TB <u>Lifetime</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>112 N. Mechanic Street</u>		d. STREET ADDRESS <u>112 N. Mechanic Street</u>	
3. NAME OF DECEASED (Type or print) <u>Lawrence Daniel Easterday</u>		4. DATE OF DEATH <u>March 3 19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	9. AGE (In years last birthday) <u>82</u> yrs. <u>5</u> Months <u>4</u> Days
11. BIRTHPLACE (County & State, or foreign country) <u>Near Sharpsburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Conrad Easterday</u>		14. MOTHER'S MAIDEN NAME <u>Abbie Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Clarence Easterday Sharpsburg Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung hemorrhage</u> DUE TO (b) <u>An infiltrating mass in the upper right lobe - probably malignant.</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u>50</u> days.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 22, 1962</u> to <u>March 3 19 62</u> that (I) (we) last saw the deceased alive on <u>March 3, 1962</u> , and that death occurred at <u>.....M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Walter H. Shealy</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>		22b. DATE SIGNED <u>Sharpsburg, Md. 3/6/62.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 6-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Sharpsburg Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert E. Seaf</u> ADDRESS <u>Williamport, Md</u>		25a. REC'D BY REGISTRAR <u>7 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>	



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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03804

03800

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b> c. LENGTH OF STAY IN 1b <b>12 Hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Williamsport</b> d. STREET ADDRESS <b>Williamsport</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Evelyn Holmes Ebersole</b>		4. DATE OF DEATH <b>3 14 19 62</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12.9.1914</b>
9. AGE (In years last birthday) <b>47</b>		10. IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Laundry Mat.</b>	
11c. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Md.</b>		11d. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Warren M Seymore</b>		14. MOTHER'S MAIDEN NAME <b>Martha E Holmes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214.09.8388</b>	
17. INFORMANT <b>Richard M Ebersole</b>		Address <b>Rural Williamsport Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Hypertensive crisis</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>14 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Williamsport</b>		20f. (City or town) (County) (State) <b>Williamsport Washington Md</b>	
21. I certify that (1) (this hospital) attended the deceased from <b>3-13 1962</b> to <b>3-14 1962</b> , that (1) (we) last saw the deceased alive on <b>3-14 1962</b> , and that death occurred <b>14</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>M. E. Byrkit</b>		22b. DATE SIGNED <b>3-16-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. E. Byrkit</b>		22d. ADDRESS <b>Williamsport Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3.17.62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn</b>		23d. LOCATION (City, town or county) (State) <b>Williamsport Washington Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard F. Shore</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 20 '62</b>	
ADDRESS <b>Williamsport Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kane</b>	

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## MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03806

03802

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wash County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>52 1/2 East Antietam St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM ARTHUR FAHRNEY</b>				4. DATE OF DEATH Month Day Year <b>March 29 1962 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 13 1881</b>	
9. AGE (In years last birthday) <b>80 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mad Beaver Creek Wash Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William O. Fahrney</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Hartle</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No --</b>				16. SOCIAL SECURITY NO. <b>172-03-3700 A.</b>			
17. INFORMANT <b>Paul Fahrney</b>				Address <b>108 Fairground Ave Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vas. Accident</b> DUE TO (b) <b>Gen. arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3-29-62</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 day</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Spa</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3/29</b> , 19 <b>62</b> , to <b>3/29</b> , 19 <b>62</b> ; that (I) (two) last saw the deceased alive on <b>3/29</b> , 19 <b>62</b> , and that death occurred at <b>11 P.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Louie G. Groff</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>APR 3 '62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Louie G. Groff</b>				22d. ADDRESS <b>119 E. Antietam</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/31/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Smithsburg Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>APR 3 '62</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove cards 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
03808 CERTIFICATE OF DEATH 03804															
1. PLACE OF DEATH a. COUNTY <i>Washington</i> <i>Hagerstown</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <i>(D.C.)</i> b. COUNTY <i>Prince George's</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> d. STREET ADDRESS <i>5015 27th Ave. Hillcrest Hgts</i> 1618-22											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>				c. LENGTH OF STAY IN 1b				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Hagerstown Hospital</i>				f. DATE OF DEATH <i>3</i> 25 19 <i>62</i>				g. AGE (In years last birthday) <i>62</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
3. NAME OF DECEASED (Type or print) <i>Rowena Mable FEERRAR</i>				4. DATE OF DEATH <i>3</i> 25 19 <i>62</i>				5. SEX <i>F</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>MAY 24 1899</i> 9. AGE (In years last birthday) <i>62</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>Williamsport Lycoming PA</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>IRA Stepp</i>				14. MOTHER'S MAIDEN NAME <i>Lulu Bender</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT <i>Ralph E. Ferrar R.O.#1 Jersey Shore Pa.</i> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>540.0</i> DUE TO <i>Lobular Pneumonia</i> Conditions, if any, which gave rise to immediate cause (b) <i>Gastric Ulcer, Chronic</i> (c) <i>Hyper-tensive Cardiovascular disease. Cholecystopathia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hyper-tensive Cardiovascular disease. Cholecystopathia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>One week</i> <i>unknown</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year <i>19</i> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 22, 1961</i> to <i>March 25, 1962</i> that (I) <del>(we)</del> last saw the deceased alive on <i>March 25, 1962</i> , and that death occurred at <i>6:45 A.M.</i> from the causes and on the date stated above.				22a. SIGNATURE <i>Young E. Chun</i> M.D. 22b. DATE SIGNED <i>March 25-1962</i>				22c. PHYSICIAN'S NAME (Type) <i>YOUNG E. CHUN</i> 22d. ADDRESS <i>1500 Penna. Ave Hagerstown, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>3/28/62</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Jersey Shore</i>				23d. LOCATION (City, town or county) (State) <i>Jersey Shore Lycoming PA.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. Owen Kellman</i> ADDRESS <i>Jersey Shore Pa.</i>				25a. REC'D BY REGISTRAR <i>MAR 28 '62</i>				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>							

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

03809

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03805

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md</b>		c. LENGTH OF STAY IN 1b <b>75 yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Maryland</b>		d. STREET ADDRESS <b>31 W. Bethel Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>31 W. Bethel Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Amos</b> Middle <b>(no)</b> Last <b>Felmon</b>		4. DATE OF DEATH Month <b>Mar</b> Day <b>4</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>90</b> yrs.
9. AGE (In years last birthday) <b>90</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>	
11. BIRTHPLACE (State or foreign country) <b>Mercersburg Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-20-0461</b>	
17. INFORMANT <b>Mrs. Nathan William</b>		Address <b>30 W Bethel St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease with congestive failure</b> (c) <b>Not known</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 3, 1962</b> to <b>March 4, 1962</b> that (I) (we) last saw the deceased alive on <b>March 3, 1962</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>B. B. Kneisley</b>		22b. DATE SIGNED <b>March 6, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington Street Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 10 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson</b>		25a. REC'D BY REGISTRAR <b>March 12 '62</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneisley</b>	

(M)

03209

CERTIFICATE OF DEATH

03209

Registration

In accordance with

the provisions of the

Act

(No)

Section

of the

Registrar

General

Office

has been duly registered in accordance with the provisions of the Act

and the Registrar has signed the Certificate of Death

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03810						03806					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)					
a. COUNTY			Washington			e. STATE			b. COUNTY		
			MARYLAND						Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Hagerstown			2 weeks			03 Hagerstown					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Washington County Hospital						434 S. Potomac Street					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			5. SEX		
First Middle Last						Month Day Year					
Noah Garfield Ford						March 15 1962					
6. COLOR OR RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH			9. AGE (In years last birthday)		
Male			White			Feb. 27 1881			81 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)		
Machinist						Aircraft			Boonesboro Md.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME			12. CITIZEN OF WHAT COUNTRY?		
John Bradley						Emma Frances Horine			U.S.A		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.			17. INFORMANT		
No									22 West Side Ave. Beulah G Kauffman Hagerstown Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction											
155.1 DUE TO Arteriosclerotic heart disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Adenocarcinoma of the gall bladder was the immediate cause of this illness											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
Non functioning gall bladder; emphysema; arthritis, lumbodorsal											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year											
Hour - min. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 5 - 3 - 55, 19, to death, 19, that (I) (we) last saw the deceased alive on March 14, 1962 and that death occurred at 2:30 AM from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type)		
Robert F. Keadle						March 15, 1962			Robert F. Keadle		
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY		
Burial						March 18-62			Boonesboro Cemetery		
24. FUNERAL DIRECTOR'S SIGNATURE						24b. ADDRESS			25a. REC'D BY REGISTRAR		
Albert L. Williamsport, Md									DATE MAR 19 '62		
25b. REGISTRAR'S SIGNATURE						25c. REGISTRAR'S SIGNATURE			25d. REGISTRAR'S SIGNATURE		
									Carlton L. Frank		

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03710

03710

Washington

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Washington County Hospital

Washington County Hospital

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Washington County Hospital



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03811

03807

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>347 N. Cleveland Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Elizabeth</b> First Middle Last <b>Elizabeth Blanche Gardner</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>March 4 1962</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Feb. 1, 1898</b>
<b>9. AGE</b> (In years last birthday) <b>64</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Hagerstown, Md.</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b> <b>Edward Mongan</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Daisy Strock</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes give year or dates of service)	
<b>16. SOCIAL SECURITY NO.</b> <b>216014-6354</b>		<b>17. INFORMANT</b> Address <b>James H. Gardner Hagerstown, Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis Of Liver</b> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>General Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b> <b>Recent</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>2-27-</b> <b>1962</b> , to <b>3-4-</b> <b>1962</b> that (I) (we) last saw the deceased alive on <b>3-4-</b> <b>1962</b> , and that death occurred at <b>2:20 P.M.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Dr. E. W. Ditto, Jr.</b>		<b>22b. DATE SIGNED</b> <b>3-5-62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. E. W. Ditto, Jr.</b>		<b>22d. ADDRESS</b> <b>215 W. Washington St., Hagerstown, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>3-7-62</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Hagerstown, Md.</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Scott F. Minnich &amp; Son</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 7 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles L. Minnich</b>			

MEDICAL CERTIFICATION

11860

## CERTIFICATE OF DEATH

03812

03808

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			
c. LENGTH OF STAY IN b. <b>6 DAYS</b>				d. STREET ADDRESS <b>125 E. ANTIETAM ST</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH VIRGINIA GARLING</b>				4. DATE OF DEATH Month Day Year <b>MARCH 7 1962</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 30 1898</b>	
9. AGE (In years last birth day) <b>63 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>ALEXANDER H KNIGHT</b>			
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT <b>MR. HARRY M GARLING HAGERSTOWN MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic coronary vascular disease</b> DUE TO <b>Acute myocardial infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Generalized arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes M</b>							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 2 '62</b> , 19... to <b>Mar 7 '62</b> , 19... that (I) (we) last saw the deceased alive on <b>March 7 &amp; 19 62</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Harold R. Titch Jr</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/6/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Physician acting while family H R TRITCH JR. M. D. Dr out of town</b>				22d. ADDRESS <b>302 N POTOMAC ST. HAGERSTOWN MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-10-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles M. Rouse</b> ADDRESS <b>SUPER-ROUSER FUNERAL HOME HAGERSTOWN MARYLAND</b>				25a. REC'D BY REGISTRAR <b>MAR 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. The funeral director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03813 CERTIFICATE OF DEATH 03809

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN b <u>4 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Md. State Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg Md - 15X-2</u> d. STREET ADDRESS <u>1 Rural</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAUL EDWARD GAYLOR</u>		4. DATE OF DEATH Month Day Year <u>MARCH 12 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>set 21/1917</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>29</u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Walter Gaylor</u>		14. MOTHER'S MAIDEN NAME <u>Ella Haysett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>230-20-0497</u>		16. SOCIAL SECURITY NO. <u>230-20-0497</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC HYPERTROPHY</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>PULMONARY EMPHYSEMA</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SEVERAL YEARS</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the <u>deceased</u> ) attended the deceased from <u>3-8-1962</u> to <u>3-12-1962</u> that (I) <u>—</u> last saw the deceased alive on <u>3-12-1962</u> and that death occurred at <u>12:15 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Antonio U. Pallagrosi</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLAGROSI</u>		22b. DATE SIGNED <u>1500 PA AVE HAGERSTOWN MD</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>	23b. DATE THEREOF <u>3/16/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>—</u>	23d. LOCATION (City, town or county) (State) <u>Michael Va Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gantner</u> ADDRESS <u>Gaithersburg Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 20 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Finner</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03814

03810

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY in 1b <u>68 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Md. State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> <u>1646-2</u> d. STREET ADDRESS <u>3605 Taylor St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Douglas</u> Middle <u>Blaine</u> Last <u>GRAY</u>		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>14</u> Year <u>1962</u>					
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>2-15-23</u>	<b>9. AGE</b> (In years last birthday) <u>39</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Photographer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Syracuse, N.Y.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>John Campbell Gray</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Goodheart</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unable to locate</u>		<b>17. INFORMANT</b> <u>deceased</u> Address <u>  </u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular pneumonia</u> 143X DUE TO <u>Carcinoma of floor of mouth</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>one week</u> <u>15 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a.m. <u>  </u> p.m. Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan. 5</u> <u>1962</u> <b>to</b> <u>March 14</u> <u>1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>March 14</u> <u>1962</u> <b>and that death occurred at</b> <u>10:50 PM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Young E. Chun</u> M.D.		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>March 15 1962</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>YOUNG E. CHUN</u>		<b>22d. ADDRESS</b> <u>1500 Penna. Ave. Hagerstown, Md</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Reburial</u>		<b>23b. DATE THEREOF</b> <u>3-15-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Georgetown Medical School</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Washington D.C.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Al R. Hoffman</u>		<b>ADDRESS</b> <u>Hagerstown Md</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 19 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. S. Kline</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
ISM 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03815

03811

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN b. <u>22 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>10 Marbern Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Charles Lynn Gregg</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>March 18 19 62</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 12, 1920</u>		<b>9. AGE</b> (In years last birthday) <u>41</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Night Engineer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Aircraft</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, Penna.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Charles Garfield Gregg</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Jessie Carroll</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>WW 2</u>				<b>16. SOCIAL SECURITY NO.</b> <u>216-14-6810</u>		<b>17. INFORMANT</b> Address <u>Mrs. Chas. L. Gregg 10 Marbern Rd. Hagerstown, Md.</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 hrs.</u> <u>?</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify</b> that (I) <u>(this hospital)</u> attended the deceased from <u>March 15, 1962</u> to <u>March 18, 1962</u> that (I) <u>(two)</u> last saw the deceased alive on <u>March 18, 1962</u> and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <u>Lloyd A. Hoffner</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3/19/62</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Lloyd A. Hoffner</u>						<b>22d. ADDRESS</b> <u>214 N. Potomac St.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>3/21/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rest Haven Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Hagerstown Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u> <u>Wm. A. Hoffner</u>						<b>25a. REC'D BY REGISTRAR</b> <u>MAR 21 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>					

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3/1/15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNDAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03816  
03812

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN, MD.</b> c. LENGTH OF STAY IN b <b>FEW MIN.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON CO. HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL 1 CLEAR SPRING, MD.</b> d. STREET ADDRESS <b>NONE</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN IRA GROVE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>6</b> Year <b>19 62</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 10, 1882</b> 9. AGE (In years last birthday) <b>80 yrs.</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b> 11. BIRTHPLACE (County & State, or foreign country) <b>WASH. CO. MD.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>DANIEL GROVE</b>		14. MOTHER'S MAIDEN NAME <b>CHRISTINA STECK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS ANNA GROVE</b>		Address <b>ROUTE 1, CLEAR SPRING MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <b>Chronic Hypertensive</b> } (c) <b>Cardiac Dis.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 days</b> <b>3 months</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, lectory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1, 1962</b> to <b>Mar. 6, 1962</b> that (I) (we) last saw the deceased alive on <b>Mar. 5, 1962</b> , and that death occurred at <b>12 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>David R. Brewer</b> 22c. PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>		22b. DATE SIGNED <b>3/7/62</b> 22d. ADDRESS <b>Clear Spring Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/9/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>WESTERN PIKE, CLSPG. MD.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Margaret Rowland</b>		25a. REC'D BY REGISTRAR <b>MAR 12 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Finner</b>	

03815

STATEMENT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03817

03813

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b> d. STREET ADDRESS <b>Route 4</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>Harry Oscar Harbaugh</b>			<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>27</b> Year <b>1962</b>		
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>Sept. 12, 1900</b>		<b>9. AGE</b> (In years last birthday) <b>61</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>27</b> Days <b>27</b> Hours <b>27</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farm-Owner</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Lantz, Md.</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>			<b>13. FATHER'S NAME</b> <b>Oscar Harbaugh</b>		
<b>14. MOTHER'S MAIDEN NAME</b> <b>Rebecca Holtzman</b>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		
<b>16. SOCIAL SECURITY NO.</b> <b>215-36-6952</b>			<b>17. INFORMANT</b> <b>Mrs. Lydia M. Harbaugh Hag. Rt. 4</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-20.0</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>arteriosclerotic heart disease</b> (c) <b>2 days</b> DUE TO <b>2 yrs +</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. <b>10:25 A</b> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) <b>21. I certify that (I) (this hospital) attended the deceased from 16 Dec. 1960 to 27 MAR. 1962 that (I) (we) last saw the deceased alive on 27 MARCH 1962, and that death occurred at 10:25 A.M. from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <b>Richard T. Binford</b> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <b>RICHARD T. BINFORD, M. D.</b> <b>22b. DATE SIGNED</b> <b>28 MARCH, 62</b> <b>22d. ADDRESS</b> <b>1135 POTOMAC AVENUE HAGERSTOWN, MD.</b> <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>3-29-62</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Green Hill Cemetery</b> <b>23d. LOCATION</b> (City, town or county) (State) <b>Waynesboro, Pa.</b> <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Scott F. Minnich &amp; Son Hagerstown, Md.</b> <b>25a. REC'D BY REGISTRAR</b> <b>MAR 29 '62</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>					



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OFFICE OF STATE

WASHINGTON, D.C. 20540

WASHINGTON, D.C. 20540

SECRET

March 15, 1962

WASHINGTON, D.C. 20540

WASHINGTON, D.C. 20540

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*Washington, D.C. 20540*

March 15, 1962

March 15, 1962

*Richard T. Bingham*

RICHARD T. BINGHAM, U.S.

1155 OTTOMAN AVENUE, WASHINGTON, D.C.

WASHINGTON, D.C. 20540

WASHINGTON, D.C. 20540

1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03818

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03814

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>1/2 Hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clear Spring Rt.#2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>				d. STREET ADDRESS <b>Spicklers</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>POWERS</b> Last <b>HARP</b>				4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1962</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 15, 1883</b>		9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b>	IF UNDER 24 HRS. Hours <b>78</b> Min. <b>78</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Chewsville, Wash. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>David Harp</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Beard</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Wilbur U. Harp, Boonesboro, Md. Rt.#2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>4-20-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>coronary thrombosis</b> <b>arterio-sclerosis</b> DUE TO <b>arterio-sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b> sudden</b> <b> years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Howard N. Weeks</b> EXAMINER'S NAME (Type) <b>Howard N. Weeks</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>3/20/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/22/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Hagerstown Wash Co., Md.</b>	
23. FUNERAL DIRECTOR <b>Andrew K. Coffman, Hagerstown, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAR 23 '62</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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03819

CERTIFICATE OF DEATH

03815

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1213 SHERMAN AVENUE</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b> d. STREET ADDRESS <b>1213 SHERMAN AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ARTHUR DAVID HASENBUHLER</b>				4. DATE OF DEATH Month Day Year <b>MARCH 22 19 62</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 4 1922</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DETECTIVE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD. STATE POLICE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS HASENBUHLER</b>				14. MOTHER'S MAIDEN NAME <b>MABEL V BUTTS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES WW 2</b>		16. SOCIAL SECURITY NO. <b>215-26-1230</b>		17. INFORMANT <b>MRS. A D HASENBUHLER HAGERSTOWN MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>coronary atherosclerosis</b> (c) <b>seer yes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/21</b> , 19 <b>62</b> , to <b>3/24</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3/21</b> , 19 <b>62</b> , and that death occurred at <b>4 P.M.</b> , from the causes and on the date stated above.							
22e. SIGNATURE <b>Howard N. Weeks</b> M.D.				22b. DATE SIGNED <b>MARCH 24 1962</b>			
22c. PHYSICIAN'S NAME (Type) <b>HOWARD N WEEKS M. D.</b>				22d. ADDRESS <b>136 N POTOMAC ST. HAGERSTOWN MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-24-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. House</b>				25a. REC'D BY REGISTRAR <b>MAR 30 '62</b>		25b. REGISTRAR'S SIGNATURE <b>William S. House</b>	
25. SUTHER-ROUSE FUNERAL HOME HAGERSTOWN MARYLAND							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card, papers, Pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03820

03817

<b>1. PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN b. <b>10 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b> d. STREET ADDRESS <b>22 BROADWAY</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>FLORENCE</b> Middle <b>VIRGINIA</b> Last <b>HOCKMAN</b>		<b>4. DATE OF DEATH</b> Month <b>MARCH</b> Day <b>10</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>MAY 13 1876</b>
<b>9. AGE</b> (In years last birthday) <b>85 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>85</b> Days <b>0</b>	<b>11. IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>CULPEPPER VIRGINIA</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>VIRGINIA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>JOHN W JENKINS</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>FRANCES V JENKINS</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>	
<b>17. INFORMANT</b> <b>MRS HELEN NEWCOMER HAGERSTOWN MARYLAND</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>arteriosclerosis genl.</b> (c) <b>arteriosclerosis genl.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Yeast Infection</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>year</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <b>19</b> e.m. <b>19</b> p.m.	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>2/15/59</b> <b>19</b> to <b>3/10/62</b> <b>19</b> , that (I) (we) last saw the deceased alive on <b>3/9/62</b> <b>19</b> , and that death occurred at <b>2pm</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Howard N Weeks</b> M.D.		<b>22b. DATE SIGNED</b> <b>3-12-62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>HOWARD N WEEKS M.D.</b>		<b>22d. ADDRESS</b> <b>136 N POTOMAC ST. HAGERSTOWN MARYLAND</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>	<b>23b. DATE THEREOF</b> <b>3-13-62</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>REST HAVEN CEMETERY</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Super-Rouzer Funeral Home</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 15 '62</b>	<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kline</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03821

03816

1. PLACE OF DEATH e. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Co. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Wash.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u> STREET ADDRESS <u>RD 6 - Hagerstown, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma</u> <u>Clara</u> <u>Hollenshead</u>		4. DATE OF DEATH Month Day Year <u>March</u> <u>1</u> <u>1962</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1879</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Welsh Run, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>David Angle</u>		14. MOTHER'S MAIDEN NAME <u>Moriah Hawbaker</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>RD 6</u> <u>Frank E. Hollenshead - Hagerstown, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED PERITONITIS</u> <u>572.1</u> DUE TO (b) <u>PERFORATED SIGMOID DIVERTICULITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHOGENIC CA OF RT. LUNG &amp; MEDIASTINAL METASTASES</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>						
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/1/62</u> to <u>3/1/62</u> , 19 <u>62</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>3/1/62</u> , 19 <u>62</u> , and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.						
22a. SIGNATURE <u>John A. Moran M.D.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/2/62</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. MORAN M.D.</u>		22d. ADDRESS <u>215 W. WASHINGTON ST.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		23b. DATE THEREOF <u>3/4/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Shanks Cem.</u>		23d. LOCATION (City, town or county) (State) <u>near Greencastle, Pa.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich. Greencastle, Pa.</u>		ADDRESS <u>Greencastle, Pa.</u>		25a. REC'D BY REGISTRAR DATE <u>6 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>

1883

1883

The following is a list of the  
 names of the persons who  
 have been elected to the  
 office of the Board of  
 Directors of the  
 City of New York for the  
 year 1883.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 7 and 8 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03822

## CERTIFICATE OF DEATH

03818

<b>1. PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN b. <b>2 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>1929 YORK ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>CHARLES TYLER HOUCK</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>MARCH 20 1962</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>FEBRUARY 26 1909</b>
<b>9. AGE</b> (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>CAR ESTIMATOR</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>AUTO BODY REPAIR</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>WASHINGTON MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>JOHN LUTHER HOUCK</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>CATHERINE MOFFETT</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-09-8532</b>	
<b>17. INFORMANT</b> <b>MRS. CHARLES T HOUCK</b>		<b>Address</b> <b>HAGERSTOWN MARYLAND</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hypertensive Cardio Vascular Disease</b> DUE TO (b) <b>67</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>40 hrs</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>3-19-62</b> , <b>19</b> , to <b>3-20</b> , <b>1962</b> , that (I) (we) last saw the deceased alive on <b>3-20-62</b> , and that death occurred at <b>6 P.M.</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>A. E. W. Ditto Jr.</b> M.D.		<b>22b. DATE SIGNED</b> <b>3-20-62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>E.W. DITTO JR. M.D.</b>		<b>22d. ADDRESS</b> <b>215 W WASHINGTON ST. HAGERSTOWN MARYLAND</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>3-23-62</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>REST HAVEN CEMETERY</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>SUTER-ROUZER FUNERAL HOME</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 27 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. House</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03823						03819					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			Washington			a. STATE			Maryland		
			MARYLAND			b. COUNTY			Washington		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Hagerstown			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Hagerstown		
c. LENGTH OF STAY in lb			Life			d. STREET ADDRESS			25 Glenside Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM?					
Washington County Hospital (DOA)						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED						4. DATE OF DEATH					
(Type or print)			Mary Margaret			Last			Month		
			Houser			Day			Year		
5. SEX			6. COLOR OR RACE			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH		
Female			White			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			January 30, 1904		
									9. AGE (In years last birthday)		
									58 yrs.		
									IF UNDER 1 YEAR		
									Months		
									Days		
									Hours		
									Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY					
Housewife						Own Home					
11. BIRTHPLACE (County & State, or foreign country)						12. CITIZEN OF WHAT COUNTRY?					
Hagerstown, Md.						USA					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
David E. Kershner						Laura Emma Tronte					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.					
No						None					
17. INFORMANT						Address					
Mr. Roy M. Houser						25 Glenside Ave. Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Coronary occlusion											
420.0 DUE TO											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.											
(b) Arterio sclerotic heart disease											
DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED?											
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
2Dc. TIME OF INJURY											
Hour a.m. Month, Day, Year											
p.m. 19											
2Dd. INJURY OCCURRED											
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
2Df. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 2/22/62 to 3/31/62, 1962, that (I) (we) last saw the deceased alive on 3/17/62 and that death occurred at 7:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE											
Eldon D. Woodlander M.D.											
22b. DATE SIGNED											
3/31/62											
22c. PHYSICIAN'S NAME (Type)											
Eldon D. Woodlander											
22d. ADDRESS											
Hagerstown Md											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
Burial											
23b. DATE THEREOF											
April 2, 1962											
23c. NAME OF CEMETERY OR CREMATORY											
Green Lawn Cemetery											
23d. LOCATION (City, town or county) (State)											
Williamsport Md.											
24. FUNERAL DIRECTOR'S SIGNATURE											
Rest Haven Funeral Chapel Hagerstown, Md.											
25a. REC'D BY REGISTRAR											
DATE APR 3 '62											
25b. REGISTRAR'S SIGNATURE											
Arthur S. Kraus											



03853

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Washington County Hospital (304)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03824  
CERTIFICATE OF DEATH  
03820

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 4</u>		d. STREET ADDRESS <u>R # 4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>				a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Lee</u> Last <u>HULL</u>				4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 27, 1882</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Malinda Hull</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Name <u>Miss Mary Hull R # 4</u> Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular Pneumonia</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral hemorrhage</u> (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>7 Weeks</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 16, 1962</u> to <u>March 4, 1962</u> that (I) <u>(no)</u> last saw the deceased alive on <u>March 4, 1962</u> and that death occurred at <u>4:30</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Young E. Chun</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>March 4, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>				22d. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/7/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u> <u>Wm. G. Stork</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 6 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03825

03821

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>49 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D. O. A. Wash. Co. Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1019 Rose Hill Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ruth Irene Hungate</b>				4. DATE OF DEATH <b>March 4 1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 18, 1911</b>	
9. AGE (In years last birthday) <b>50 yrs.</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b>		IF UNDER 24 HRS. Hours <b>4</b> Min. <b>1962</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Martinsburg, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Abram French</b>				14. MOTHER'S MAIDEN NAME <b>Maude Mongan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give year or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>William H. Hungate</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>44-5X</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>Malignant Hypertension</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>2 min</b> <b>5 yrs</b> <b>10 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>e.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/7</b> to <b>3/12</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3/2</b> , 19 <b>62</b> , and that death occurred at <b>1:30</b> P.M. from the causes and on the date stated above.				22. SIGNATURE <b>Paul Harrison</b> M.D. <b>3-5-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Paul Harrison, M. D.</b>		22d. ADDRESS <b>318 N. Potomac St., Hagerstown, Md.</b>		22b. DATE SIGNED <b>3-5-62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-6-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b> ADDRESS <b>Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>7 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Krane</b>	



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FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03826				Items 88, 9 & 14 Film G308 3/8/62 iwk				03822			
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>30 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>465 Mitchell Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lee</u> Middle <u>Roy</u> Last <u>Johnson</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>2</u> Year <u>19 62</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>unknown 1890</u>		9. AGE (In years last birthday) <u>71 approx</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fertilizer-Chemical</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Taylor Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>421-03-1038</u>		17. INFORMANT Address <u>Mrs. John H. Smith 465 Mitchell Ave. Hagerstown, Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Ac. Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>DUE TO</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>IMMEDIATE</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/2/62</u> , 19 <u>62</u> , to <u>3/2/62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/2/62</u> , 19 <u>62</u> , and that death occurred at <u>1:24</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Ralph F. Young</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>3/3/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ralph F. Young M.D.</u>				22d. ADDRESS <u>Williamsport, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/4/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Horst</u>				ADDRESS <u>Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>6 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03827

## CERTIFICATE OF DEATH

03823

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b> c. LENGTH OF STAY IN lb <b>60yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>650 Penna. Ave.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland.</b> d. STREET ADDRESS <b>650 Penna Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>William T Johnson</b> First Middle Last		<b>4. DATE OF DEATH</b> <b>Mar 5 19 62</b> Month Day Year	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Nov 17 1879</b> 9. AGE (In years last birthday) <b>82</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Hotel</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Frederick Md.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA.</b>
<b>13. FATHER'S NAME</b> <b>Unknown</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>220-09-7428</b> <b>17. INFORMANT</b> <b>Walter E Campher</b> Address <b>650 Penna Ave.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> <b>congestive failure</b> DUE TO <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>malnutrition</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b> <b>years</b>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>3/3</b> , 19 <b>62</b> to <b>3/5</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>3/5</b> , 19 <b>62</b> , and that death occurred at <b>7</b> A.M. from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Howard N. Weeks, M. D.</b>		<b>22b. DATE SIGNED</b> <b>3/7/62</b>	<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Howard N. Weeks, M. D.</b>
<b>22d. ADDRESS</b> <b>136 N. Potomac Street</b>		<b>22e. REC'D BY REGISTRAR</b> <b>22f. REGISTRAR'S SIGNATURE</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Mar 9 1962</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>
<b>23d. LOCATION</b> (City, town or county) <b>Hagerstown Md.</b>		<b>23e. (State)</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John R Watson</b>		<b>25. ADDRESS</b> <b>Hagerstown Md.</b>	

YR A15 (4)  
15M 9/60

(M)

(1)

03887

03883

CERTIFICATE OF DEATH

Washington

Washington

negotiation, Washington

negotiation, Washington

850 Pennsylvania Ave.

850 Pennsylvania Ave.

10:15 am

10:15 am

Kate Colored

Kate Colored

Templeton Hotel

Templeton Hotel

Union

Union

no

no

no

George Washington

Howard ... ..

Howard ... ..

Howard ... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03828

03824

1. PLACE OF DEATH a. COUNTY <i>Washington</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montg.</i>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown Md</i>		c. LENGTH OF STAY IN 1b <i>1 1/2 mo 18 da</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Germanstown Rural Md -</i>															
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Ind - State Hosp -</i>				d. STREET ADDRESS <i>15X-2</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last <i>FRANCES LAVINIA JONES</i>				4. DATE OF DEATH Month Day Year <i>March 7, 1962</i>															
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec 11th 1905</i>													
9. AGE (In years last birthday) <i>56 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Seneca, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>													
13. FATHER'S NAME <i>Reginald Cross</i>				14. MOTHER'S MAIDEN NAME <i>Ermma J. Whaling</i>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Rheumatoid arthritis &amp; cervical spondylitis and quadripareisis</i>								INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>								20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 19</i> 19 <i>60</i> to <i>March 7</i> 19 <i>62</i> that (I) ( <del>we</del> ) last saw the deceased alive on <i>March 7</i> 19 <i>62</i> , and that death occurred at <i>11:55</i> PM, from the causes and on the date stated above.								22a. SIGNATURE <i>Victor L. Ramos, M.D.</i>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <i>VICTOR L. RAMOS, M.D.</i>								22d. ADDRESS <i>Western Md. State Hospital Hagerstown, Maryland</i>				22e. REC'D BY REGISTRAR DATE <i>MAR 12 '62</i>				22f. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 10, '62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Monacacy</i>		23d. LOCATION (City, town or county) (State) <i>Beallsville, Md</i>													
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest C. Fisher Gaithersburg Md</i>																			

MEDICAL CERTIFICATION

03882

03882

(M)

(I)

James J. Whiting  
James, Vol. 11.2.2

Reginald C. C. C.

1903

1903



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
be retained by the hospital or attending physician.  
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Reg. Dist. No. 03825

03829

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> <u>NONE</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. COUNTY HOSPITAL</u>		d. STREET ADDRESS <u>150 S. Potomac Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>JOHN RUSSELL JUDD, JR.</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>MARCH 19 1962</u>	
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>MARCH 19 1962</u>
<b>9. AGE</b> (In years lost birthday) <u>—</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <u>18 MIN.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MD.</u>	
<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>JOHN RUSSELL JUDD, SR.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>VIOLET VIRGINIA FLOWERS</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <u>MOTHER</u>		<b>Address</b> <u>HAGERSTOWN, MD.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Atrial ectasis, bilateral</u> DUE TO (b) <u>15-min</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Immaturity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. <b>ACTUAL SIGNATURE</b> <u>Harold H. Gist</u> M.D. <b>ADDRESS</b> (Street, city or town, state) <b>DATE SIGNED</b>			
<b>PHYSICIAN'S NAME</b> (Type) <u>DR. H. H. GIST, HAGERSTOWN, MD.</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>21 Mar 62</u>		<b>22b. DATE THEREOF</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Wash. Co. Hosp.</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Hagerstown</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John Schaffer, adms. Wash. Co. Hosp.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE MAR 22 '62</u>	
<b>ADDRESS</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur E. Kenna</u>	

2-060328



1  
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03830  
CERTIFICATE OF DEATH  
03826

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SHANKTOWN, MD.</b> c. LENGTH OF STAY IN lb <b>56 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RESIDENCE</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SHANKTOWN</b> d. STREET ADDRESS <b>NONE</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES D. KAYLOR</b>				4. DATE OF DEATH Month Day Year <b>MAR. 4, 1962 19</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 10, 1874</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>HAMPSHIRE CO. W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ANDREW KAYLOR</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE MILES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES</b>				16. SOCIAL SECURITY NO. <b>SPANISH AMERICAN</b>			
17. INFORMANT <b>MRS ZETA MURRAY KAYLOR, SHANKTOWN, MD.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Dis</b> 4-20-60 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Fractured Hip (Nonunion) 1960</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5-yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 15, 1960</b> to <b>Mar. 4, 1962</b> that (I) (we) last saw the deceased alive on <b>Mar. 4, 1962</b> and that death occurred at <b>3:00 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>David R. Brewer</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/5/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>				22d. ADDRESS <b>Clear Spring Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAR. 7, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SHANKTOWN CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>SHANKTOWN, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Margaret Rowland</b>				ADDRESS <b>CLEAR SPRING, MD.</b>		25a. REC'D BY REGISTRAR <b>MAR 8 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>			

038230

DATE OF DEATH

038230

CHARLES WHITE  
WIFE  
BORN 10/1/1914  
DIED 10/1/1914  
CAUSE OF DEATH  
MURDER

CHARLES WHITE  
WIFE  
BORN 10/1/1914  
DIED 10/1/1914  
CAUSE OF DEATH  
MURDER



N

1630

0385



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03832

CERTIFICATE OF DEATH

03828

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>INDIAN SPRINGS</b> c. LENGTH OF STAY IN 1b <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>RESIDENCE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>INDIAN SPRINGS</b> d. STREET ADDRESS <b>RURAL</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MICHAEL TANNER KEEFER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>17</b> Year <b>19 62</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/1871</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	9. AGE (In years last birthday) <b>90</b> yrs. IF UNDER 1 YEAR Months <b>8</b> Days <b>2</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
13. FATHER'S NAME <b>PETER KEEFER</b>		11. BIRTHPLACE (County & State, or foreign country) <b>COVE GAP, PA.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA EICHELBERGER</b>	
17. INFORMANT <b>S.A. KEEFER</b>		Address <b>INDIAN SPRINGS, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERY OCCLUSION WITH MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b>unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> a.m. <b></b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>December 15, 19 59</b> to <b>March 17, 19 62</b> , that (I) (we) last saw the deceased alive on <b>March 16, 19 62</b> , and that death occurred at <b>12:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Archie Robert Cohen</i> M.D.		22b. DATE SIGNED <b>3/17/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>		22d. ADDRESS <b>Clear Spring, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/19/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>WESTERN PIKE MD.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Margaret Reuland</i> ADDRESS <b>CLEAR SPRING, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 20 '62</b>	25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>



SEP 80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03833

CERTIFICATE OF DEATH

03829

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> c. LENGTH OF STAY in 1b <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>120 N. MAIN ST.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> d. STREET ADDRESS <u>120 NORTH MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>MARGARET ELIZABETH KERNS</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>17</u> Year <u>1962</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>MARCH</u> Day <u>22</u> Year <u>1894</u>		9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months <u>11</u> Days <u>25</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SCHOOL TEACHER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BOONSBORO WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID O. LAKIN</u>				14. MOTHER'S MAIDEN NAME <u>DELLA HOFFMAN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-09-9628</u>				17. INFORMANT <u>KENNETH KERNS BOONSBORO MD.</u> Address <u>IND.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>196.2</u> DUE TO <u>Coronary Thrombosis -</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Cancer of spine</u> (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u> Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>September 2, 1961</u> to <u>March 17, 1962</u> that (I) (we) last saw the deceased alive on <u>March 16, 1962</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>G. W. Hedden</u>										22b. DATE SIGNED <u>3/18/62</u>				22c. PHYSICIAN'S NAME (Type) <u>G. W. Hedden</u>					
22d. ADDRESS <u>Boonsboro, Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22f. PHYS. <input checked="" type="checkbox"/>				22g. ADDRESS <u>Boonsboro, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>MARCH 20 1962</u>				23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>				23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. CO. MD.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Post</u>										25a. REC'D BY REGISTRAR <u>MAR 22 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>					
ADDRESS <u>Boonsboro MD.</u>										DATE									

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## FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### 03834 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03830

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Dauphin</b> ✓			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Harrisburg</b> <b>75X-3</b>		d. STREET ADDRESS <b>15 S. 15 Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>205 E. Lincoln Ave</b>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Anna Jane King</b>				4. DATE OF DEATH <b>March 4 19 62</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1887</b>	9. AGE (In years last birthday) <b>75 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Carlisle, Penn.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Fyler</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Beecher</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>George L. King Harrisburg, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4-20-62</b> } DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>General Arterio Sclerosis</b> (c) <b>recent</b> (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>recent</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>E. W. Ditto Jr.</b>		M.D.		DATE SIGNED <b>March 4, 1962</b>			
EXAMINER'S NAME (Type) <b>215 W. Washington St. Hag. Md.</b>		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-6-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Harrisburg, Pa.</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Scott F. Minnich &amp; Son Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 7 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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FOR STATE  
DEPT. USE



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MEDICAL DEPARTMENT  
0323

201 E. Lincoln Ave

Home 111

John F. Ford

Barry Ford

General Service

General Service

0323

Medical Department

0323

Medical Department



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR AIS (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03835 CERTIFICATE OF DEATH 03831

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>6 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Gateway Conv Home</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>1 Y.M.C.A.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>KELLER</u> Last <u>LANTZ</u>			4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1962</u>		
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 3 1878</u> 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Md. near Leitersburg Wash Co</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Charles M. Lantz</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Katherine Zentmyer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>219-20-3836</u> 17. INFORMANT <u>Webster W. Lantz 115 West Magnolia Ave Hagerstown Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Acute Cardiac Failure</u> DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Diabetic Gangrene Both legs amputated</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>9 yrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July 1953</u> to <u>Mar 12, 1962</u> , that (I) (we) last saw the deceased alive on <u>Mar 12, 1962</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>David R. Brewer M.D.</u>			22b. DATE SIGNED <u>3/14/62</u>		
22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			22d. ADDRESS <u>Clear Spring Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3/15/62</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hall Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>			25a. REC'D BY REGISTRAR <u>Mar 19 '62</u>		
ADDRESS <u>Hagerstown Md</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03836

03832

<b>1. PLACE OF DEATH</b> e. COUNTY WASHINGTON MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 321 LINGANORE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE		4. DATE OF DEATH Month Day Year MARCH 19 19 62	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 321 LINGANORE AVENUE		First Middle Last CARRIE VIOLA LAWRENCE		9. AGE (In years last birthday) 70 yrs.	
3. NAME OF DECEASED (Type or print) CARRIE VIOLA LAWRENCE		5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 4, 1892		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY IN HER OWN HOME		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO. MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE FRANK MILLS		14. MOTHER'S MAIDEN NAME MARGARET E. SHRADER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 220-28-9101		17. INFORMANT GEORGE H. LAWRENCE HAGERSTOWN, MD.	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhages; 1 <sup>st</sup> June 1, 1961 422.1 } DUE TO Conditions, if any, which gave rise to immediate cause (b) " 2 <sup>nd</sup> Mar 19, 1962 (c) arterio sclerotic Cardio vascular disease (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 year 5 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 62	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 June 1961 to 19 Mar 1962, that (I) (we) last saw the deceased alive on 19 Mar 1962, and that death occurred at 6:05 PM, from the causes and on the date stated above.		22a. SIGNATURE DR. FRANK F. LUSBY M.D.		22b. DATE SIGNED 21 Mar 62	
22c. PHYSICIAN'S NAME (Type) DR. FRANK F. LUSBY		22d. ADDRESS 220 N. POTOMAC ST. HAGERSTOWN, MD.		22e. REC'D BY REGISTRAR MAR 27 '62	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/22/1962		23c. NAME OF CEMETERY OR CREMATORY ST. PAUL CEMETERY	
23d. LOCATION (City, town or county) WASHINGTON, MARYLAND		23e. REGISTRAR'S SIGNATURE Arthur S. Thomas		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE SUTER-ROUZER FUNERAL HOME		24a. ADDRESS 305 N. POT. ST. HAG. MD.		24b. DATE MAR 27 '62	

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Handwritten notes and signatures, including "J. H. [illegible]" and "J. H. [illegible]".

Handwritten notes and signatures, including "J. H. [illegible]" and "J. H. [illegible]".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03837 CERTIFICATE OF DEATH 03833

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>3 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u> d. STREET ADDRESS <u>2112 VIRGINIA AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GUY MOHLER LONG</u>		4. DATE OF DEATH Month Day Year <u>MARCH 8 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 18. 1882</u>
9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u>2</u> Days <u>19</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEIRCHANT GENERAL STORE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DOWNSVILLE WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSHUA LONG</u>		14. MOTHER'S MAIDEN NAME <u>IDA C. WELTY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-14-9381</u>	
17. INFORMANT <u>MISS THELMA BAKER WILLIAMS</u>		Address <u>PORT MD. R.I.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart failure?</u> DUE TO (c) <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>fx of 3 Ribs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>3-5</u> 19 <u>62</u> to <u>3-8</u> 19 <u>62</u> that (2) (we) last saw the deceased alive on <u>3-7</u> 19 <u>62</u> , and that death occurred at <u>3:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Byrkit</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3-9-62</u>
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MAR. 10. 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MANOR CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>NEAR TILGHMANTON MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Bast</u>		ADDRESS <u>BOONSBORO MD</u>	
25a. REC'D BY REGISTRAR DATE <u>MAR 13 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03838 CERTIFICATE OF DEATH 03834

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>30 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>428 WEST WASH. ST.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u> d. STREET ADDRESS <u>1 428 W. WASH. ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LULA</u> First Middle Last 4. DATE OF DEATH <u>MARCH 5 1962</u> Month Day Year		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>JULY 16 1876</u> 9. AGE (In years last birthday) <u>85</u> yrs. 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> 11. IF UNDER 24 HRS. Hours <u>19</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>LOCUST GROVE WASH. CO. MD. U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>DANIEL SMITH</u> 14. MOTHER'S MAIDEN NAME <u>MATILDE GELTACHER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>214-09-6979</u> 17. INFORMANT <u>MISS ALBERTA LONG</u> Address <u>428 WEST WASHINGTON ST. HAGERSTOWN MD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General arteriosclerosis and</u> <u>450.0</u> DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>5-10 years</u> (c) <u>5-10 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m. Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>Aug 1 1958</u> to <u>Mar 5 1962</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>Mar 1 1962</u> and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Edward W. Ditto III</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>		22b. DATE SIGNED <u>3/5/62</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>217 West Washington St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>MARCH 8 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ROCKERSVILLE CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>ROCKERSVILLE WASH. CO. MD</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Dard - Boonsboro MD</u> ADDRESS 25a. REC'D BY REGISTRAR <u>DATE MAR 13 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

03839  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03835

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>6 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1015 Hamilton Blvd.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>1015 Hamilton Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A.</b> Last <b>Martin</b>				4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 9, 1897</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b>		11. IF UNDER 24 HRS. Hours <b>4</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Martin</b>				14. MOTHER'S MAIDEN NAME <b>Anna Gearhart</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-38-1613</b>		17. INFORMANT Address <b>Joseph P. Martin, Maugansville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (b) <b>arteriosclerosis</b> (c) <b>arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>sudden</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>3/23/62</b>							
ACTUAL SIGNATURE <b>Howard N. Weeks</b> M.D. EXAMINER'S NAME (Type) <b>Howard N. Weeks, M. D.</b>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/25/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Grove,</b>		22d. LOCATION (City, town, or country) (State) <b>Near Greencastle, Pa.</b>	
23. FUNERAL DIRECTOR <b>A. E. Minnich</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 27 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	

MEDICAL CERTIFICATION

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WILLIAMSBURG, N.Y.

Nov. 28, 1951

Chief of Police

W. L. Smith, Esq.

Dear Sir:

Very truly yours,

W. L. Smith, Esq.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03841  
03837

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b> d. STREET ADDRESS <b>936 CHESTNUT STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>TRA CLIFFORD McCLELLAND</b>				4. DATE OF DEATH Month Day Year <b>MARCH 5 1962</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCTOBER 6, 1880</b>	
9. AGE (In years last birthday) <b>81 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STATIONARY ENGINEER</b>		11. BIRTHPLACE (County & State, or foreign country) <b>LINGANORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W McCLELLAND</b>				14. MOTHER'S MAIDEN NAME <b>AGNES V BARNES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>197-10-8458A</b>			
17. INFORMANT <b>MRS. HAROLD L SMITH HAGERSTOWN MARYLAND</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>420-1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/5/60</b> , 19 <b>62</b> , to <b>3/5</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3/5</b> , 19 <b>62</b> , and that death occurred at <b>10P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Howard N Weeks</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/5/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>HOWARD N WEEKS M. D.</b>				22d. ADDRESS <b>136 N POTOMAC ST. HAGERSTOWN MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-8-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles M. Rouzer</b> SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND				25a. REC'D BY REGISTRAR DATE <b>MAR 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>	

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03842

CERTIFICATE OF DEATH

03838

Item 1 Film G309 3/27/62

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>W. Va</b> b. COUNTY <b>MORGAN</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERKELEY SPRINGS</b> <b>85X'3</b>	
c. LENGTH OF STAY IN b. <b>2 WKS</b>		d. STREET ADDRESS <b>RFD # 2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>TINA CATHERINE MICHAEL</b>		4. DATE OF DEATH <b>MARCH 19, 1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 26, 1895</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>HOOCHVILLE, W. Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM TEDRICK</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA LINTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. S. Myers - PITTSBURGH, Pa.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b>			
4-20-62 DUE TO <b>Atherosclerotic Heart Disease</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Hypertensive Cardiovascular Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonitis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>W. T. Layman</b> attended the deceased from <b>March 6, 1962</b> to <b>March 19, 1962</b> , that (I) <b>W. T. Layman</b> saw the deceased alive on <b>March 19, 1962</b> , and that death occurred at <b>9:10 pm.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. T. Layman</b>		22b. DATE SIGNED <b>3-21-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>		22d. ADDRESS <b>5 Public Square Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-22-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. ZION</b>		23d. LOCATION (City, town or county) (State) <b>MORGAN Co. W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sam S. Hunter - Berkeley Springs W. Va.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 23 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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inter-  
mediate  
1 year

Coronary Insufficiency  
Atherosclerotic Heart Disease  
Hypertensive Cardiovascular Disease

Pneumonia

3-21-02

5 Public Square  
Hagerstown, Maryland

William T. Layman, M.D.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03843

03839

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Washington</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 wk.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Co. Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Penna.</b> <span style="float: right;">b. COUNTY <b>Franklin</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Waynesboro</b> d. STREET ADDRESS <b>87 W. Main St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>LLOYD CALVIN MILLER</b> First Middle Last				<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>7</b> Year <b>1962</b>											
<b>5. SEX</b> <b>M</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Aug. 22, 1909</b>		<b>9. AGE</b> (In years last birthday) <b>52</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>11. IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Pattern Maker</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington Co., Md.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Chauncey C. Miller</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Edith Weddle</b>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>173 03 3836</b>				<b>17. INFORMANT</b> <b>Mrs. Lloyd C. Miller</b>				Address <b>Waynesboro, Penna.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF URINARY BLADDER</b> DUE TO (b) <b>GENERALIZED CARCINOMATOSIS</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <b>NONE</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>1-28-56</b> , 19....., to <b>3-7-</b> 19....., that (I) (we) last saw the deceased alive on <b>3-7-62</b> 19....., and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.															
<b>22e. SIGNATURE</b> 						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>J. G. WARDEN, M. D.</b>						<b>22d. ADDRESS</b> <b>832 Potomac Ave., Hagerstown, Md.</b>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>3/10/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Green Hill</b>				<b>23d. LOCATION (City, town or county)</b> (State) <b>Waynesboro, Penna.</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> 						<b>ADDRESS</b> <b>Waynesboro, Penna.</b>				<b>25e. REC'D BY REGISTRAR</b> <b>MAR 12 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FILL IN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
03845									
03841									
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>4 Weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Western Md State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>103 East Washington St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>William McPherson MILLER</b> First Middle Last Sr. 4. DATE OF DEATH <b>3 23 1962</b> Month Day Year					5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Nov 23 1885</b> 9. AGE (In years last birthday) <b>76</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Dealer Self Employed</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown Wash Co Md</b> 11. BIRTHPLACE (County & State, or foreign country) <b>USA</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					13. FATHER'S NAME <b>John Miller</b> 14. MOTHER'S MAIDEN NAME <b>Mary Butts</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No --</b> 16. SOCIAL SECURITY NO. <b>165-10-8555</b> 17. INFORMANT <b>Mrs Minnie B. Miller</b> Address <b>103 E. Washington</b> St					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) <b>1810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lobular pneumonia</b> (c) <b>Necrotizing renal papillitis</b> <b>Carcinoma of bladder</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>one week</b> <b>unknown</b> <b>2 years</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>2-27</b> to <b>3-23</b> , 19 <b>62</b> that (I) <del>was</del> last saw the deceased alive on <b>3-23</b> , 19 <b>62</b> , and that death occurred at <b>9:55</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Young E. Chun</b> 22c. PHYSICIAN'S NAME (Type) <b>YOUNG E. CHUN</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. ADDRESS <b>1500 Penna. Ave Hagerstown, Md.</b> 22d. DATE SIGNED <b>3-23-1962</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>3/25/62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b> 23d. LOCATION (City, town or country) (State) <b>Hagerstown Wash Co Md.</b>					24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b> ADDRESS <b>Hagerstown Md.</b> 25a. REC'D BY REGISTRAR <b>MAR 27 '62</b> 25b. REGISTRAR'S SIGNATURE <b>William E. Thomas</b>				

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Arthur S. Hanes

VR A15 (4)  
15M 9/60

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Section 1. Station - 200 Haverdown, Pa.

April 1902 - 200 Haverdown, Pa. Station, Pa.

Section 1. Station - 200 Haverdown, Pa.

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Section 1. Station - 200 Haverdown, Pa.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

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DR. SECONDARI

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03847

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03843

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BOONSBORO c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MAPLEVILLE ROAD		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BOONSBORO d. STREET ADDRESS MAPLEVILLE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALBERTOS D. MULLENDORF First Middle Last		4. DATE OF DEATH MARCH 8, 1962 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 15, 1900 Month Day Year
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE AGENT		9b. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR Months Days 0 23 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE AGENT		10b. KIND OF BUSINESS OR INDUSTRY GENERAL INSURANCE	
11. BIRTHPLACE (County & State, or foreign country) ROCKERSVILLE WASH. CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NOAH O. MULLENDORF		14. MOTHER'S MAIDEN NAME CLEMMIE EASTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) NO.		16. SOCIAL SECURITY NO. 213-10-7033	
17. INFORMANT MRS. FRANCES MULLENDORF		Address BOONSBORO MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 17 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 3-5, 1962, to March 8, 1962, that (I) (we) last saw the deceased alive on March 5, 1962, and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Joseph K. SECONDARI M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. ADDRESS BOONSBORO MD	
22c. PHYSICIAN'S NAME (Type) Joseph K. SECONDARI		22d. ADDRESS BOONSBORO MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 11, 1962	
23c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		23d. LOCATION (City, town or county) (State) BOONSBORO WASH. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John E. Bass		25a. REC'D BY REGISTRAR DATE MAR 13 '62	
ADDRESS BOONSBORO MD		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

03813

03813

CERTIFICATE OF DEATH

WILLIAMSON

WILLIAMSON

WILLIAMSON

WILLIAMSON

WILLIAMSON

MARBLE VILLAGE

MARBLE VILLAGE

ALBERTA D. WILLIAMSON

ALBERTA D. WILLIAMSON

WHITE

WHITE

INSURANCE POLICY

INSURANCE POLICY

JOHN O. WILLIAMSON

JOHN O. WILLIAMSON

NO.

215-10-1000 MRS. FRANCES WILLIAMSON

WILLIAMSON

WILLIAMSON

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03848

Item 9 11m G509 3/19/62 1wk

CERTIFICATE OF DEATH

03844

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 40 years		d. STREET ADDRESS 545 W. Church St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roy Edward Nunamaker		4. DATE OF DEATH March 11 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1902
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machanic		10b. KIND OF BUSINESS OR INDUSTRY Ser. Station	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Nunamaker		14. MOTHER'S MAIDEN NAME Nettie Gordan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Viola Beall Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) Cormary Thrombosis arterio-sclerosis (General)		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gulmonary Angioma.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 11, 1962, to March 11, 1962, that (I) (we) last saw the deceased alive on March 11, 1962, and that death occurred at 9 A.M. from the causes and on the date stated above.			
22a. SIGNATURE JH. Beachley		22b. DATE March 13, 1962	
22c. PHYSICIAN'S NAME (Type) JH. Beachley		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-13-62	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE MAR 14 '62	
		25b. REGISTRAR'S SIGNATURE Charles S. Hume	



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# FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN lb <u>Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				d. STREET ADDRESS <u>2204 Rowland Road</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Eric</u> Middle <u>May</u> Last <u>Palmer</u>			4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>19 62</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Sept. 8, 1888</u>			9. AGE (in years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Tilghmanton, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>George Moats</u>						14. MOTHER'S MAIDEN NAME <u>Rebecca Rohrer</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. A. C. Palmer 1216 Glenwood Ave. Hagerstown, Md.</u>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>903.0</u> DUE TO <u>fractured skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>accidental fall</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Depression</u>														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Stool slipped from person climbing onto it in an attempt at hanging herself. She then fell striking her head on basement floor.</u>														
20c. TIME OF INJURY Hour <u>6:30</u> m. Month, Day, Year <u>Mar 1 19 62</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Hagerstown</u>		(County) <u>Wash.</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>H. N. WEEKS</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <u>H. N. WEEKS</u>						DATE SIGNED <u>3/5/62</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>3/5/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			22d. LOCATION (City, town, or country) <u>Hagerstown Md.</u>			
23. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>						24a. REC'D BY REGISTRAR DATE <u>Mar 6 '62</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

Item 18 309 2-14-62 ams				MAYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND				03846			
03850				CERTIFICATE OF DEATH			
1. PLACE OF DEATH e. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) e. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		1669.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western Maryland State Hospital</b>		d. STREET ADDRESS <b>9718 Wichita Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>TERESA</b>		First <b>TERESA</b> Middle <b>BLAKE</b> Last <b>QUINN</b>		4. DATE OF DEATH <b>MARCH 10 1962</b>		Month <b>MARCH</b> Day <b>10</b> Year <b>1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 13, 1883</b>	
9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Francis Blake</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Kelley</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>579-09-1345</b>	
17. INFORMANT <b>Ruth Anderson Same as #2 (Daughter)</b>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION 10/10/11/12/13/14/15/16/17/18/19/20/21/22/23/24/25/26/27/28/29/30/31/32/33/34/35/36/37/38/39/40/41/42/43/44/45/46/47/48/49/50/51/52/53/54/55/56/57/58/59/60/61/62/63/64/65/66/67/68/69/70/71/72/73/74/75/76/77/78/79/80/81/82/83/84/85/86/87/88/89/90/91/92/93/94/95/96/97/98/99/100/101/102/103/104/105/106/107/108/109/110/111/112/113/114/115/116/117/118/119/120/121/122/123/124/125/126/127/128/129/130/131/132/133/134/135/136/137/138/139/140/141/142/143/144/145/146/147/148/149/150/151/152/153/154/155/156/157/158/159/160/161/162/163/164/165/166/167/168/169/170/171/172/173/174/175/176/177/178/179/180/181/182/183/184/185/186/187/188/189/190/191/192/193/194/195/196/197/198/199/200/201/202/203/204/205/206/207/208/209/210/211/212/213/214/215/216/217/218/219/220/221/222/223/224/225/226/227/228/229/230/231/232/233/234/235/236/237/238/239/240/241/242/243/244/245/246/247/248/249/250/251/252/253/254/255/256/257/258/259/260/261/262/263/264/265/266/267/268/269/270/271/272/273/274/275/276/277/278/279/280/281/282/283/284/285/286/287/288/289/290/291/292/293/294/295/296/297/298/299/300/301/302/303/304/305/306/307/308/309/310/311/312/313/314/315/316/317/318/319/320/321/322/323/324/325/326/327/328/329/330/331/332/333/334/335/336/337/338/339/340/341/342/343/344/345/346/347/348/349/350/351/352/353/354/355/356/357/358/359/360/361/362/363/364/365/366/367/368/369/370/371/372/373/374/375/376/377/378/379/380/381/382/383/384/385/386/387/388/389/390/391/392/393/394/395/396/397/398/399/400/401/402/403/404/405/406/407/408/409/410/411/412/413/414/415/416/417/418/419/420/421/422/423/424/425/426/427/428/429/430/431/432/433/434/435/436/437/438/439/440/441/442/443/444/445/446/447/448/449/450/451/452/453/454/455/456/457/458/459/460/461/462/463/464/465/466/467/468/469/470/471/472/473/474/475/476/477/478/479/480/481/482/483/484/485/486/487/488/489/490/491/492/493/494/495/496/497/498/499/500/501/502/503/504/505/506/507/508/509/510/511/512/513/514/515/516/517/518/519/520/521/522/523/524/525/526/527/528/529/530/531/532/533/534/535/536/537/538/539/540/541/542/543/544/545/546/547/548/549/550/551/552/553/554/555/556/557/558/559/560/561/562/563/564/565/566/567/568/569/570/571/572/573/574/575/576/577/578/579/580/581/582/583/584/585/586/587/588/589/590/591/592/593/594/595/596/597/598/599/600/601/602/603/604/605/606/607/608/609/610/611/612/613/614/615/616/617/618/619/620/621/622/623/624/625/626/627/628/629/630/631/632/633/634/635/636/637/638/639/640/641/642/643/644/645/646/647/648/649/650/651/652/653/654/655/656/657/658/659/660/661/662/663/664/665/666/667/668/669/670/671/672/673/674/675/676/677/678/679/680/681/682/683/684/685/686/687/688/689/690/691/692/693/694/695/696/697/698/699/700/701/702/703/704/705/706/707/708/709/710/711/712/713/714/715/716/717/718/719/720/721/722/723/724/725/726/727/728/729/730/731/732/733/734/735/736/737/738/739/740/741/742/743/744/745/746/747/748/749/750/751/752/753/754/755/756/757/758/759/760/761/762/763/764/765/766/767/768/769/770/771/772/773/774/775/776/777/778/779/780/781/782/783/784/785/786/787/788/789/790/791/792/793/794/795/796/797/798/799/800/801/802/803/804/805/806/807/808/809/810/811/812/813/814/815/816/817/818/819/820/821/822/823/824/825/826/827/828/829/830/831/832/833/834/835/836/837/838/839/840/841/842/843/844/845/846/847/848/849/850/851/852/853/854/855/856/857/858/859/860/861/862/863/864/865/866/867/868/869/870/871/872/873/874/875/876/877/878/879/880/881/882/883/884/885/886/887/888/889/890/891/892/893/894/895/896/897/898/899/900/901/902/903/904/905/906/907/908/909/910/911/912/913/914/915/916/917/918/919/920/921/922/923/924/925/926/927/928/929/930/931/932/933/934/935/936/937/938/939/940/941/942/943/944/945/946/947/948/949/950/951/952/953/954/955/956/957/958/959/960/961/962/963/964/965/966/967/968/969/970/971/972/973/974/975/976/977/978/979/980/981/982/983/984/985/986/987/988/989/990/991/992/993/994/995/996/997/998/999/1000/1001/1002/1003/1004/1005/1006/1007/1008/1009/1010/1011/1012/1013/1014/1015/1016/1017/1018/1019/1020/1021/1022/1023/1024/1025/1026/1027/1028/1029/1030/1031/1032/1033/1034/1035/1036/1037/1038/1039/1040/1041/1042/1043/1044/1045/1046/1047/1048/1049/1050/1051/1052/1053/1054/1055/1056/1057/1058/1059/1060/1061/1062/1063/1064/1065/1066/1067/1068/1069/1070/1071/1072/1073/1074/1075/1076/1077/1078/1079/1080/1081/1082/1083/1084/1085/1086/1087/1088/1089/1090/1091/1092/1093/1094/1095/1096/1097/1098/1099/1100/1101/1102/1103/1104/1105/1106/1107/1108/1109/1110/1111/1112/1113/1114/1115/1116/1117/1118/1119/1120/1121/1122/1123/1124/1125/1126/1127/1128/1129/1130/1131/1132/1133/1134/1135/1136/1137/1138/1139/1140/1141/1142/1143/1144/1145/1146/1147/1148/1149/1150/1151/1152/1153/1154/1155/1156/1157/1158/1159/1160/1161/1162/1163/1164/1165/1166/1167/1168/1169/1170/1171/1172/1173/1174/1175/1176/1177/1178/1179/1180/1181/1182/1183/1184/1185/1186/1187/1188/1189/1190/1191/1192/1193/1194/1195/1196/1197/1198/1199/1200/1201/1202/1203/1204/1205/1206/1207/1208/1209/1210/1211/1212/1213/1214/1215/1216/1217/1218/1219/1220/1221/1222/1223/1224/12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03220

Washington

Mariontown

Western Maryland State Hospital

97187 John Avenue

College Park

Female White

Aug. 15, 1953

Own Home

Washington D. C.

Holtsville

Francis Blake

Barbara Kelly

no

579-09-1345

Rich Anderson Baltimore 12 (Trappes)

Collington

Holy Trinity Church

3/13/52

Booth

Francis Casch's Son, Hyattsville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03851 CERTIFICATE OF DEATH 03847

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hagerstown RDC</u>				d. STREET ADDRESS <u>Hagerstown RDC</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Susanna E. Reiff</u>				4. DATE OF DEATH Month Day Year <u>March 12, 1962</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/31/1871</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Reid, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Eschleman</u>				14. MOTHER'S MAIDEN NAME <u>Susanna Horst</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>ROC Mrs. Martin Showalter Hwy., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 3, 1962</u> to <u>Mar. 12, 1962</u> that (I) (we) last saw the deceased alive on <u>Mar. 11, 1962</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>R.A. Bell</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Mar. 13, 1962.</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.A. Bell, M.D.</u>				22d. ADDRESS <u>119 N. Potomac St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		23b. DATE THEREOF <u>3/15/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Paradise Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Wash. Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich - Greencastle, Pa.</u>				25a. REC'D BY REGISTRAR <u>Mar 15 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



15220

5140



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. RACE: [illegible]  
5. DATE OF BIRTH: [illegible]  
6. PLACE OF BIRTH: [illegible]  
7. OCCUPATION: [illegible]  
8. CAUSE OF DEATH: [illegible]  
9. MANNER OF DEATH: [illegible]  
10. SIGNATURE OF MEDICAL EXAMINER: [illegible]  
11. DATE: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove chain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03853

## CERTIFICATE OF DEATH

03849

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b <b>2 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wash County Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>847 West Washington St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>IRENE CHARLOTTE RUTH</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>March 24 1962 19</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>July 18 1883</b>
<b>9. AGE</b> (In years last birthday) <b>78 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Pa.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Lewis Lohman</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Miller</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT</b> <b>Miss Helen M.L. Ruth</b>		<b>Address</b> <b>847 W. Washington St</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>420.0</b> DUE TO <b>Coronary Thrombosis and B.B. Block.</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <b>Arteriosclerotic Heart Disease.</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 days</b> <b>3 yaers.</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <b>Diabetes Mellitus</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State) <b>July 1959 Mar. 24, 1962</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Mar. 24, 1962</b> <b>8AM</b> <b>to</b> <b>Mar. 24, 1962</b> <b>8AM</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Mar. 24, 1962</b> <b>and that death occurred at</b> <b>8AM</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>R.A. Bell</b> <b>R.A. Bell, M.D.</b>		<b>22b. DATE SIGNED</b> <b>Mar. 26, 1962.</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type)		<b>22d. ADDRESS</b> <b>119 N. Potomac St. Hagerstown, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/26/62</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rest Haven Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Hagerstown Wash Co Md</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Andrew K. Coffman</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 27 '62</b>	
<b>ADDRESS</b> <b>Hagerstown Md.</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>James S. Jones</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

<b>03854</b>				<b>03850</b>			
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>30 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash County Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>141 West Franklin St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>WILLIAM</u> Middle <u>HENRY</u> Last <u>SELBY</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>2</u> Year <u>1962</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 14 1885</u>	
<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Md.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>Noah P. Selby</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ella M. Slonaker</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>---</u>				<b>16. SOCIAL SECURITY NO.</b> <u>---</u>			
<b>17. INFORMANT</b> <u>Miss Ruth V. Selby</u> Address <u>206 E. Franklin St</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 420.0 DUE TO (b) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent CVA - (2-3-62) with residual hemiparesis, left.</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 minutes</u> <u>2 years</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Feb. 3 1962</u> to <u>March 2 1962</u> , that (I) (we) last saw the deceased alive on <u>March 2 1962</u> , and that death occurred at <u>7:55 pm</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>W. T. Layman</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3-3-</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>William T. Layman, M.D.</u>				<b>22d. ADDRESS</b> <u>100 Professional Arts Bldg. Hagerstown, Maryland</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/5/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt View Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Union Bridge Carroll Co Md</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Mar 6 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR :15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03855  
CERTIFICATE OF DEATH  
03851

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY in 1b <b>14 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>765 S. Potomac St.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>765 S. Potomac St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>QUINCY</b> First <b>SHAFER</b> Middle <b>SHAFER</b> Last		4. DATE OF DEATH <b>March 28, 1962</b> Month <b>March</b> Day <b>28,</b> Year <b>19 62</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10, 1881</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Building</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Bedford Co. Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Henry Shaffer</b>			14. MOTHER'S MAIDEN NAME <b>Charlotte Robb</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>175-16-8891</b>		17. INFORMANT <b>J.W. Shaffer</b> Address <b>Bedford, Pa.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 4 22 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Arteriosclerotic Cardiovascular disease</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 day</b> <b>3 p.m.</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>27 Mar 1962</b> to <b>28 Mar 1962</b> , that (I) (we) last saw the deceased alive on <b>28 Mar 1962</b> , and that death occurred at <b>5 P</b> M, from the causes and on the date stated above.						
22a. SIGNATURE <b>J.F. Lusby</b>		M.D. <b>FF. Lusby</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>28 Mar 62</b>
22c. PHYSICIAN'S NAME (Type) <b>FF. Lusby</b>		22d. ADDRESS <b>2304 Potomac St Hagerstown Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-31-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Schellsburg Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Schellsburg-Bedford Co. Pa.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Ralph Mickle</b>				25a. REC'D BY REGISTRAR <b>APR 2 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

03821

03822

Washington

Virginia

Washington

Argentine

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Argentine

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Feb 8, 1901

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March

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U.S.A.

Home Building

Home Building

Garfield House

Garfield House

Bedford, Va.

Bedford, Va.

to

Garfield House

Garfield House

Garfield House

Garfield House

Garfield House



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03856 CERTIFICATE OF DEATH 03852

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY in lb 3 Month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural La Plata d. STREET ADDRESS Welcome e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HOWARD Charles SHARER 4. DATE OF DEATH Month Day Year MARCH 28 1962		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Aug. 12 1898 9. AGE (in years last birthday) 63 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman 11. BIRTHPLACE (County & State, or foreign country) Williamsport Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Sharer		14. MOTHER'S MAIDEN NAME Sarah Grosh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. 220-10-3963 Mrs. C. G. Payne Williamsport Md. 17. INFORMANT Address 29 S. Conococheague St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 CORONARY THROMBOSIS DUE TO (b) CORONARY ATHEROSCLEROSIS DUE TO (c) GENERALIZED ARTERIOSCLEROSIS CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (the deceased) attended the deceased from 12-18 1961, to 3-28 1962 that (I) (we) last saw the deceased alive on 3-28-1962, and that death occurred at 4:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE Antonio U. Pallagristi M.D. 22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGRISTI 22b. ADDRESS 1500 Pa Ave. Hagerstown Md.		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF March 31-62 23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery 23d. LOCATION (City, town or county) (State) Williamsport Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Md. 25a. REC'D BY REGISTRAR DATE MAR 30 '62 25b. REGISTRAR'S SIGNATURE Albert S. Thane			

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03857

## CERTIFICATE OF DEATH

Reg. Dist. No. 03853

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reeder Nursing Home</b>				d. STREET ADDRESS <b>Rural Middletown</b>			
3. NAME OF DECEASED (Type or print) First <b>Edgar</b> Middle <b>L.</b> Last <b>Sheffer</b>				4. DATE OF DEATH Month <b>3</b> Day <b>29</b> Year <b>1962</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/27/1875</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>storekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>general store</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>George Sheffer</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Shank</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>---</b>			
17. INFORMANT <b>Mrs. Everett Moser, Middletown, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: <b>450</b> IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> DUE TO <b>Banquane of left leg</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs 3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 18, 1962</b> to <b>March 29, 1962</b> , that I last saw the deceased alive on <b>March 29, 1962</b> , and that death occurred at <b>8 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. W. He Van</b> M.D.				ADDRESS (Street, city or town, state) <b>Boonsboro</b>			
PHYSICIAN'S NAME (Type) <b>G. W. He Van</b>				DATE SIGNED <b>3/29/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3/31/1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>APR 2 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			





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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03855

03855

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>10 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash County Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>26 1/2 E. Franklin St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>OMAR HILL SMALL</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>March 12 1962 19</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>July 15 1894</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>retired</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Martinsburg Berkley Co Va.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>William Hill Small</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Cora Day Riner</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>317-05-7779</u>			
<b>17. INFORMANT</b> <u>Wilburn M. Wade</u>				<b>18. ADDRESS</b> <u>2923 E 4 Monument St Baltimore Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> DUE TO (b) <u>cancer of tongue</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>141-9</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Beverly N. Workman M.D.</u>				<b>22b. DATE SIGNED</b> <u>MAR 15 '62</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type)				<b>22d. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/14/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Andrew K. Coffman Hagerstown Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DATE MAR 15 '62</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Huns</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03860

03856

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>2101 Virginia Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Clora Sarah Smalts</u>		4. DATE OF DEATH <u>March 10 1962</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 28 1881</u>		9. AGE (in years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>9</u>		11. IF UNDER 24 HRS. Hours <u>3</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Hampshire County W. Va</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>Noah Haines</u>				14. MOTHER'S MAIDEN NAME <u>Drusilla Oats</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Mr. Harry Smalts</u> Address <u>2101 Virginia Ave. Hagerstown Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolus</u> 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Auricular fibrillation</u> DUE TO (c) <u>3 min</u> 3 mos																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>① Gangrene of Rt leg</u> <u>② Paralysis</u>																			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>1-1</u> , 19 <u>62</u> to <u>3-10</u> , 19 <u>62</u> that (1) (we) last saw the deceased alive on <u>3-10</u> , 19 <u>62</u> , and that death occurred at <u>3</u> M, from the causes and on the date stated above.																			
22a. SIGNATURE <u>M. E. Byrkit</u>				22b. DATE SIGNED <u>3-10-62</u>				22c. PHYSICIAN'S NAME (Type) <u>William B. Byrkit</u>				22d. ADDRESS <u>William B. Byrkit Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>March 13-62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edith V. Leaf</u>				ADDRESS <u>William B. Byrkit Md</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 14 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03861

03857

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> c. LENGTH OF STAY IN 1b <u>10 MONTHS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>REEFER NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>524 EAST FRANKLIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FANNIE E. SMITH</u>		4. DATE OF DEATH <u>MARCH 6, 1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 6 - 1868</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SAMPLES MANOR WASH. Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ADRIAN SMITH</u>		14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. CLEMMIE BAKER BOONSBORO MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Severe arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7 years</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Compensatory heart failure - Diabetic mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>February 2, 1962</u> to <u>March 6, 1962</u> that (I) (we) last saw the deceased alive on <u>March 5, 1962</u> and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Secondary</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u>		22d. ADDRESS <u>BOONSBORO MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MARCH 9, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. Co. MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Hume</u>	
ADDRESS <u>BOONSBORO MD</u>		25b. REGISTRAR'S SIGNATURE	
DATE <u>MAR 13 '62</u>			



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CENTRAL OF TEXAS

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WASHINGTON

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TO DIRECTOR

GENERAL INVESTIGATIVE DIVISION

JANIE E. SMITH

MARTIN

FEMALE WHITE X

1 May 1888

LA 0

HOUSE WIFE OWN FINE SHAPESMAN WIFE TO MR.

ADRIAN SMITH

NO RECORD

NO

NAME

MRS. GEORGE BAKER

6000 E. 1st St. S.W.

Summit of ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove page 4 from the certificate. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR:MS (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03862

CERTIFICATE OF DEATH

03858

Item 7 Film G310

4/2/62

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN TB <b>1 Week</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>16 West Wilson Blvd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>MARY WORTHAM SMITH</b>		4. DATE OF DEATH <b>March 23 1962 19</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 7 1902</b>		9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mens Shop</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Grayson County Ky.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>E.E. Wortham</b>				14. MOTHER'S MAIDEN NAME <b>Ettie Carrier</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) <b>--</b>				16. SOCIAL SECURITY NO. <b>520-16-1136</b>				17. INFORMANT <b>Mrs Myrtle Harmison 731 George St Hagerstown Md.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema, Ascites, abdominal, Auricular Fibrillation, Bundle Branch Block</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>4 4 3 X</b> DUE TO 1. <b>Hypertensive and Rheumatic Heart Disease</b> DUE TO 2. <b>unknown</b>				INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>1. 1 1/2 yrs.</b> <b>2. unknown</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>None</b>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) <b>XXXXXX</b> attended the deceased from <b>March 13 1962</b> to <b>March 22 1962</b> , that (I) <b>XXXX</b> last saw the deceased alive on <b>Mar. 20 1962</b> , and that death occurred at <b>10 am</b> , from the causes and on the date stated above.				22a. SIGNATURE <b>W.D. Layman</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>3-23-62</b>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>				22d. ADDRESS <b>5 Public Square Hagerstown, Maryland</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/26/62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Hagerstown Wash Co Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 27 '62</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thraus</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03863

CERTIFICATE OF DEATH

03859

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>9 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON CO. HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLEAR SPRING</b> d. STREET ADDRESS <b>MAIN ST.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BESSIE GILMAN SNYDER</b>		4. DATE OF DEATH <b>MARCH 25 19 62</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 24, 1894</b>
9. AGE (In years last birthday) <b>68 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>1</b>	
11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>1</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ELEMENTARY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>INDIAN SPRINGS, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANCIS P. HULL</b>		14. MOTHER'S MAIDEN NAME <b>ELIZEBETH STARLIPER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-36-3629</b>	
17. INFORMANT <b>WILLIAM HULL</b>		18. ADDRESS <b>BALTIMORE, MD. 7 3737 LOCHEARN DRIVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERY OCCLUSION WITH MYOCARDIAL INFARCTION</b> DUE TO <b>4-20</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>CARCINOMA OF THE CERVIX WITH LOCALIZED METASTASIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>10 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from <b>March 15, 1962</b> to <b>March 25, 1962</b> , that (I) (we) saw the deceased alive on <b>March 25, 1962</b> , and that death occurred at <b>12:40 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Archie Robert Cohen</b> M.D. 22b. DATE SIGNED <b>03/27/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>		22d. ADDRESS <b>Clear Spring, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MARCH 28, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>CLEAR SPRING, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Margaret Rowland</b>		25. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03865

03861

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>40 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>722 Oak Hill Ave.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>1 722 Oak Hill Ave.</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Donald</u> Last <u>Starr</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>10</u> Year <u>19 62</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Nov. 1, 1906</u>
<b>9. AGE</b> (In years last birthday) <u>55</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Furniture</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Md.</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>John J. Starr</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Kalb</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)	
<b>16. SOCIAL SECURITY NO.</b> <u>705-10-5723</u>		<b>17. INFORMANT</b> <u>Mrs. J. D. Starr</u> Address <u>722 Oak Hill Ave. Hagerstown, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Cardiac Arrhythmia</u> DUE TO <u>Acute myocardial Infarct</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>  </u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Conjunctive Heart Failure</u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>	<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb. 12</u> , 19 <u>62</u> <b>to</b> <u>March 10</u> , 19 <u>62</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>March 8</u> , 19 <u>62</u> , <b>and that death occurred at</b> <u>10AM</u> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Harold R. Tritch Jr</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>	<b>22b. DATE SIGNED</b> <u>3-12-62</u>
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Harold R. Tritch, Jr. MD</u>		<b>22d. ADDRESS</b> <u>302 N. Potomac St. Hagerstown, Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>3/12/62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rest Haven Cemetery</u>	<b>23d. LOCATION (City, town or county)</b> <u>Hagerstown</u> (State) <u>Md.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE MAR 13 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>	



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1992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03866  
03862

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u> c. LENGTH OF STAY IN 1b <u>2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clearspring</u> d. STREET ADDRESS <u>Clearspring Md RFD #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Virgie Mae Stevens</u>		4. DATE OF DEATH Month Day Year <u>March 17 19 62</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 8 1903</u>	9. AGE (In years last birthday) <u>58 yrs.</u>	IF UNDER 1 YEAR Months Days <u>3 8</u>	IF UNDER 24 HRS. Hours Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Groceries</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Near Mercersburg Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John J. Bowers</u>			14. MOTHER'S MAIDEN NAME <u>Priscilla Tosten</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-26-8128</u>		17. INFORMANT <u>Pinesburg Williamsport</u> <u>Mrs. Raymond Staley RFD #1 Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Chronic rheumatic heart disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>Unknown</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 28 1962</u> to <u>March 17, 1962</u> , that (I) (we) last saw the deceased alive on <u>March 17 1962</u> , and that death occurred at <u>7:30 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>L. L. Packer Jr</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/19/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. L. Packer Jr</u>		22d. ADDRESS <u>145 W. Washington St Hagerstown, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 20-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md</u>			25a. REC'D BY REGISTRAR DATE <u>MAR 20 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03867

## CERTIFICATE OF DEATH

03863

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b. <b>8 wks.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Co. Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Rt. #3</b> d. STREET ADDRESS <b>St. James Village</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>HARVEY LEE STOTELMYER</b> First Middle Last <b>4. DATE OF DEATH</b> <b>March 20 1962</b> Month Day Year		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>January 8, 1870</b> <b>9. AGE</b> (In years last birthday) <b>92</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retired</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Wolfesville, Fred. Co. Md.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA.</b>		<b>13. FATHER'S NAME</b> <b>John Stotelmyer</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Jane Gruber</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>None</b> <b>17. INFORMANT</b> <b>Edgar Stotelmyer, 1032 Rose Hill Ave. Hagerstown, Maryland.</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>200.2</b> DUE TO <b>Malignant Lymphoma</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Secondary Anemia</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>Washington</b> <b>(County)</b> <b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>March 20, 1962</b> <b>to</b> <b>March 20, 1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>March 20, 1962</b> <b>and that death occurred at</b> <b>10:00 PM</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>J. H. Beachley</b> <b>M.D.</b> <b>22b. DATE SIGNED</b> <b>March 21, 1962</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>J. H. Beachley</b> <b>22d. ADDRESS</b> <b>Hagerstown</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>3/23/62</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Manor Cemetery</b> <b>23d. LOCATION</b> (City, town, or county) <b>Maryland.</b> <b>(State)</b> <b>near Tilghmanton Wash. Co.</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Andrew K. Coffman</b> <b>ADDRESS</b> <b>Maryland,</b> <b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>MAR 23 '62</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kneass</b>	

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CENTRAL OF TEXAS

1422



*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be retained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03864

3868

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>6 MOS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>AVALON MANOR CONVALESCENT HOME</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>221 RIDGEMEDE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT ANNAN STOTT</b>		4. DATE OF DEATH Month Day Year <b>MARCH 25 1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 14 1889</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months Days <b>25 1962</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EXECUTIVE</b>		12. KIND OF BUSINESS OR INDUSTRY <b>ELECTRICAL SUPPLY</b>	
13. FATHER'S NAME <b>EDWIN CHESTER STOTT</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET GRAYSON GALT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES WW 1</b>		16. SOCIAL SECURITY NO. <b>214-09-0015A</b>	
17. INFORMANT <b>MRS. ROBERT A STOTT</b>		Address <b>BALTIMORE MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>sudden cardiac arrest - probable arrhythmia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>arteriosclerotic heart disease</b> (c) <b>generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cerebral arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>oct 4</b> to <b>March 25, 1962</b> that (I) (we) last saw the deceased alive on <b>March 23, 1962</b> and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John C. Stauffer</b> M.D.		22b. DATE SIGNED <b>MARCH 26 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN C STAUFFER M. D.</b>		22d. ADDRESS <b>145 S PROSPECT ST. HAGERSTOWN MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-27-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PINEY CREEK CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>TANEYTOWN MARYLAND</b>	
24. GENERAL DIRECTOR'S SIGNATURE <b>Charles R. Suter</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 30 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Lantz</b> c. LENGTH OF STAY in lb <b>61 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Lantz R.D.1</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Leroy</b> Middle <b>Stottlemeyer</b> Last <b>Stottlemeyer</b>		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>4</b> Year <b>1962</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 24, 1877</b>	<b>9. AGE</b> (In years last birthday) <b>84</b> yrs.	<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>11. IF UNDER 24 HRS.</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13. FATHER'S NAME</b> <b>Joseph Stottlemeyer</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Martha Hurley</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Mr. Glen Stottlemeyer</b>		<b>Address</b> <b>Lantz, Md.</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation, acute</b> <b>481X</b> DUE TO <b>Influenza</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>12-24 hrs.</b> <b>2-4 wks.</b>						
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from 1 March 1962 to 4 March 1962, that (I) (we) last saw the deceased alive on 4 March 1962, and that death occurred at 8:30 PM, from the causes and on the date stated above.</b>						
<b>22a. SIGNATURE</b> <b>Harry H. Youngs Jr</b>		<b>22b. DATE SIGNED</b> <b>3-6-62</b>		<b>22c. PHYSICIAN'S NAME (Type)</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/7/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Strangs</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Washington Co, Md.</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Walter J. Grove</b>		<b>ADDRESS</b> <b>Waynesboro, Penna.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 8 '62</b>		
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>						



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove cause of death and date of death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03870

03866

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SAN MAR</b> c. LENGTH OF STAY in b <b>6 1/2 MONTHS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>FAHNEY-KEDDY MEMORIAL HOME</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b> d. STREET ADDRESS <b>NORTH MAIN ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>AYCORGUS HARRISON STOFFER</b>		4. DATE OF DEATH <b>MARCH - 11 - 1962</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DECEMBER, 27 - 1875 - 86 yrs.</b>	
9. AGE (in years last birthday) <b>2</b> Months <b>14</b> Days <b>14</b> Hours <b>Min.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED EMPLOYER</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>VICTOR PRODUCTS CO. NEAR BOONSBORO WASH. CO. MD. U.S.A.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASH. CO. MD. U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EDWARD STOFFER</b>	
14. MOTHER'S MAIDEN NAME <b>LAURA GILGEOUS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO.</b>	
16. SOCIAL SECURITY NO. <b>212-14-6324</b>		17. INFORMANT <b>MRS. CLARENCE TOLTZ BOONSBORO MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446X</b> DUE TO <b>chronic glomerular nephritis</b> Conditions, if any, which gave rise to immediate cause (b) <b>7 years</b> (c) <b>generalized arteriosclerosis</b> cause last. <b>7 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 10 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 30, 1953</b> , to <b>March 9, 1962</b> , that (I) (we) last saw the deceased alive on <b>3-9-1962</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph Secondary</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDARY</b>		22d. ADDRESS <b>BOONSBORO MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MARCH 14 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John W. East</b>		25a. REC'D BY REGISTRAR <b>MAR 14 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		25c. ADDRESS <b>BOONSBORO MD</b>	

03882

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WESTERN UNION TELEPHONE COMPANY

NEW YORK, N. Y.

TO NEW YORK, N. Y.

FROM NEW YORK, N. Y.

DATE: JANUARY 27, 1950

RE: NEW YORK, N. Y.

TO NEW YORK, N. Y.

FROM NEW YORK, N. Y.

DATE: JANUARY 27, 1950

RE: NEW YORK, N. Y.

TO NEW YORK, N. Y.

FROM NEW YORK, N. Y.

DATE: JANUARY 27, 1950

RE: NEW YORK, N. Y.

TO NEW YORK, N. Y.

FROM NEW YORK, N. Y.

DATE: JANUARY 27, 1950

RE: NEW YORK, N. Y.

TO NEW YORK, N. Y.

FROM NEW YORK, N. Y.

DATE: JANUARY 27, 1950

RE: NEW YORK, N. Y.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove card 4 from the certificate and file it with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03871

03867

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>48 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>651 Court Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ava</b> First <b>Blondell</b> Middle <b>Swain</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 15, 1899</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Luray, Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Carl Kibler</b>		14. MOTHER'S MAIDEN NAME <b>Irene Ruffner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs. Marie Lorshbaugh Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Toxemia from Gangrene of Both Legs</b> (c) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>4 Wks.</b> <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from..... 19..... to..... 19....., that (I) (we) last saw the deceased alive on..... 22 Mar 1962....., and that death occurred at..... 10 P.M. .... from the causes and on the date stated above.		22. SIGNATURE <b>J. D. WILSON, M.D.</b> M.D. 22d. ADDRESS <b>135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND</b>	
22b. DATE SIGNED <b>3/23/62</b>		22c. PHYSICIAN'S NAME (Type)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-25-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		25a. REC'D BY REGISTRAR <b>MAR 27 '62</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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Frank Walker

House No.

San Jose

Local White

London

San Jose, Cal.

San Jose, Cal.

San Jose, Cal.

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San Jose, Cal.

San Jose, Cal.

State P. Minnich & Son, Incorporated, 241

Room 411, Berkeley

San Francisco, Cal.

HAD

San Jose, Cal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03872

CERTIFICATE OF DEATH

03868

1. PLACE OF DEATH e. COUNTY <b>WASHINGTON</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN b <b>8 mos</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X Williamsport</b> d. STREET ADDRESS <b>1 LEAF'S ALLEY</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PAULINE FLORA THOMPSON</b>		4. DATE OF DEATH <b>MARCH 22 1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 7, 1886</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARTINSBURG, W. VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W MOORE</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE BLAKE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>NO ONE</b>	
17. INFORMANT <b>MRS PAULINE STEVENS</b>		Address <b>HAGERSTOWN MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO <b>Coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Osteoarthritis of spine</b>		INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b> <b>Unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-11-61</b> to <b>3-22-1962</b> that (I) <b>was</b> last saw the deceased alive on <b>3-22-1962</b> and that death occurred at <b>8:25 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Young E. Chun</b> M.D.		22b. DATE SIGNED <b>3-22-1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>YOUNG E CHUN</b>		22d. ADDRESS <b>1500 Pa Ave Hagerstown MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-26-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles M Rouzer</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 27 '62</b>	
ADDRESS <b>SUTER-ROUZER FUNERAL HOME HAGERSTOWN MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbons of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03873  
CERTIFICATE OF DEATH  
03869

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>4 MOS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>135 N CANNON AVENUE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b> d. STREET ADDRESS <b>609 SUMMIT AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LOUISE JULIA THORNE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>11</b> Year <b>19 62</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 29 1905</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b>	IF UNDER 24 HRS. Hours <b>56</b> Min. <b>56</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CORSETIERE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMPLOYED</b>	11. BIRTHPLACE (County & State, or foreign country) <b>HAGERSTOWN MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>J EZRA MUSEY</b>	
14. MOTHER'S MAIDEN NAME <b>CLARA B <del>XXXX</del> WHITE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>212-24-3693</b>		17. INFORMANT <b>JEANNE M THORNE HAGERSTOWN MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Tumor - Astrocytoma</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>193.0</b> DUE TO (c) <b>18 mo</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):		INTERVAL BETWEEN ONSET AND DEATH <b>18 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 8, 1961</b> to <b>March 11, 1962</b> that (I) (we) last saw the deceased alive on <b>Mar 11, 1962</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lloyd A. Hoffman</b> 22c. PHYSICIAN'S NAME (Type) <b>LLOYD A. HOFFMAN M. D.</b>		22b. DATE SIGNED <b>3-12-62</b>	
22d. ADDRESS <b>214 N POTOMAC ST. HAGERSTOWN MARYLAND</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22f. ADDRESS <b>214 N POTOMAC ST. HAGERSTOWN MARYLAND</b>		22g. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-14-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN MEMORIAL GARDENS</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Hume</b> 24b. ADDRESS <b>SUNSHINE FUNERAL HOME HAGERSTOWN MARYLAND</b>		25a. REC'D BY REGISTRAR <b>APR 15 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		25c. ADDRESS <b>214 N POTOMAC ST. HAGERSTOWN MARYLAND</b>	

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TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03874

Reg. Dist. No. 03870

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 HAGERSTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>250 HAGER ST.</b>		d. STREET ADDRESS <b>250 HAGER ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>RAY</b> Middle <b>HERBERT</b> Last <b>VANCE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>19</b> Year <b>191962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 24, 1914</b>
9. AGE (In years last birthday) <b>47 yrs.</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>25</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHEET METAL WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REFRIGERATION</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>KENNETH C. VANCE</b>		14. MOTHER'S MAIDEN NAME <b>RETHA SHIVES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>217-18-7432</b>	
17. INFORMANT <b>MRS GOLDIE VANCE</b>		Address <b>HAGERSTOWN, MD.</b> <b>250 HAGER ST.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>420</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO <b></b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2</b> <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b></b> o. m. <b></b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Sharon N. Work</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>3/19/62</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/21/1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN MEM. GARDENS</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Margaret Rowland</b>		ADDRESS <b>CLEAR SPRING, MD.</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>	
DATE <b>MAR 22 '62</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03871

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R # 1</b> c. LENGTH OF STAY IN b <b>34 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Smithsburg-Beaver Creek Rd.</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Hagerstown R # 1</b> d. STREET ADDRESS <b>Smithsburg-Beaver Creek Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EARNEST ELLSWORTH VANDERAU</b>		4. DATE OF DEATH <b>March 15 1962 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15 1883</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	9. AGE (In years last birthday) <b>78</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>PA Greencastle Franklin Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Adam Vanderau</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Phillipy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No --</b>		16. SOCIAL SECURITY NO. <b>219-36-4822</b>	
17. INFORMANT <b>Mrs Ethel M. Shatzler Hagerstown Md. R #1</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Death of Hemorrhage</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Arterio Sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>14 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 6 1962</b> to <b>Mar 15 1962</b> that (I) (we) last saw the deceased alive on <b>Mar 15 1962</b> and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>G.A. Kohler</b> 22c. PHYSICIAN'S NAME (Type) <b>G.A. KOHLER</b>		22b. DATE SIGNED <b>Mar 17 1962</b> 22d. ADDRESS <b>Smithsburg Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/18/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Greencastle Franklin Co PA</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 20 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Travis</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03876

03872

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) b. STATE <b>MARYLAND</b> c. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>819 MEDWAY ROAD</b>				d. STREET ADDRESS <b>819 MEDWAY RD.</b>			
3. NAME OF DECEASED (Type or print) <b>MARVIN L. WEBSTER</b>				4. DATE OF DEATH <b>MARCH 8, 1962</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 17, 1916</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>21</b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>COAL CO.</b>			
11. BIRTHPLACE (State or foreign country) <b>ROCKINGHAM CO. VA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>REMUS WEBSTER</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO.</b>				16. SOCIAL SECURITY NO. <b>230-01-3169</b>			
17. INFORMANT <b>MRS. ERSCEL WEBSTER</b>				18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e)				CORONARY OCCLUSION			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				general arteriosclerosis and arteriosclerotic heart disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)				INTERVAL BETWEEN ONSET AND DEATH <b>5-10 yrs</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Edward W. Ditto III, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>MAR. 12, 1962</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>SAMPLES MANOR CEMETERY</b>				22d. LOCATION (City, town, or country) (State) <b>SAMPLES MANOR MD</b>			
23. FUNERAL DIRECTOR <b>John H. Bast</b>				24a. REC'D BY REGISTRAR <b>Boonsboro MD</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>				DATE <b>MAR 13 '62</b>			

MEDICAL CERTIFICATION

IN THE  
CITY OF  
NEW YORK  
COUNTY OF  
MADISON

FILE NO. 100-100000  
JAN 10 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03877					03873				
<b>1. PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>49 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>815 THE TERRACE</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN 03</b> d. STREET ADDRESS <b>815 THE TERRACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>ROGER NMN WHIPPLE</b>			<b>4. DATE OF DEATH</b> <b>MARCH 9 19 62</b>						
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>FEBRUARY 14 1876</b>		<b>9. AGE</b> (In years last birthday) <b>86 yrs.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>VICE-PRESIDENT</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>SHOE COMPANY</b>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>SALEM MASS.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>STEPHEN L WHIPPLE</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>AUGUSTA TRUMBULL</b>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>			<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>MRS. ROGER WHIPPLE HAGERSTOWN MARYLAND</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerosis - Generalized</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 Wks.</b> <b>2 yrs.</b> <b>10 yrs.</b>									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>19</b>		<b>(County)</b> <b>19</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from Feb 28, 1962 to Mar 9, 1962, that (I) (we) last saw the deceased alive on March 9, 1962 and that death occurred at 10:55 AM, from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>Lloyd A. Hoffman</b> M.D.					<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>3-12-62</b>		
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>LLOYD A HOFFMAN M. D.</b>					<b>22d. ADDRESS</b> <b>214 N POTOMAC ST. HAGERSTOWN MARYLAND</b>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>3-13-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ROSE HILL MAUSOLEUM</b>			<b>23d. LOCATION</b> (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>SUTER-ROUZER FUNERAL HOME</b>					<b>ADDRESS</b> <b>HAGERSTOWN MARYLAND</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAR 15 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Knecht</b>

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MEDICAL PLANT IN AMERICAN MUSEUM

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AMERICAN MUSEUM OF NATURAL HISTORY

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY		WASHINGTON		MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		HAGERSTOWN		c. LENGTH OF STAY IN b	
		12 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		WASHINGTON COUNTY HOSPITAL			
3. NAME OF DECEASED (Type or print)		First		Middle	
ANNIE		MARGARET		ZIMMERMAN	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				WASHINGTON MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
JOSEPH NISWANDER		ELIZABETH WHITMER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		216-38-0141A		HAROLD Z BREWER CLEAR SPRING MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		bleeding duodenal ulcer		INTERVAL BETWEEN ONSET AND DEATH 4 days	
5410 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		nephrosclerosis, hemolytic cystitis, arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		Fall at home fracturing hip with operation 12th March	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
2 p.m. 3/8 1962		Home		RT 4 Hagerstown Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE		Howard N Weeks		M.D.	
EXAMINER'S NAME (Type)		HOWARD N WEEKS		M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
BURIAL		3-22-62		ROSE HILL CEMETERY	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
SUPER-ROUZER FUNERAL HOME		DATE MAR 30 '62		Arthur S. Thoms	
HAGERSTOWN MARYLAND		HAGERSTOWN MARYLAND		HAGERSTOWN MARYLAND	

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, the Deputy Medical Examiner should execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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